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PRESIDENT'S FISCAL YEAR 2016 HEALTH CARE PROPOSALS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

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PRESIDENT'S FISCAL YEAR 2016 HEALTH CARE PROPOSALS

WEDNESDAY, FEBRUARY 4, 2015

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:04 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Crapo, Roberts, Cornyn, Thune, Burr, Isakson, Portman, Toomey, Coats, Heller, Scott, Wyden, Schumer, Stabenow, Cantwell, Nelson, Menendez, Carper, Cardin, Brown, Bennet, Casey, and Warner.

Also present: Republican Staff: Chris Campbell, Staff Director; Kimberly Brandt, Chief Healthcare Investigative Counsel; and Jay Khosla, Chief Health Counsel and Policy Director. Democratic Staff: Joshua Sheinkman, Staff Director; Jocelyn Moore, Deputy Staff Director; Michael Evans, General Counsel; Laura Berntsen, Senior Advisor for Health and Human Services; Elizabeth Jurinka, Chief Health Advisor; Matt Kazan, Health Policy Advisor; and Juan Machado, Professional Staff Member.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

Good morning. It is a pleasure to welcome everyone to today's hearing on the fiscal year 2016 budget for the Department of Health and Human Services, HHS.

I want to thank you, Secretary Burwell, for being here with us today. This is your first hearing before the committee since being confirmed, so welcome back in your official capacity. I told you when we were talking at your confirmation hearing that the job you now have would be a thankless one and that you were undertaking an enormous responsibility. At that time we also discussed three main areas that I encouraged you to focus on during your time at HHS: responsiveness, accountability, and independence.

I would like to talk more about each of these areas today. Let us start with responsiveness. During your confirmation hearing, I raised the importance of being responsive to Congress, and to this committee in particular. You assured me that this would be a top priority of yours as well and that under your watch we would see a marked improvement.

In the past year, this committee has written at least 20 letters to HHS or CMS, asking questions about serious issues such as

fraud prevention, hacking of the *HealthCare.gov* website, Medicaid expansion, and many others.

I understand that we have now received answers to nearly every one of those outstanding letters just in time for your appearance here today, with the last two responses coming just last week. This is a great improvement over what it has been in the past, and I appreciate the efforts being made to provide these answers to us.

However, I hope that it will not require calling you to testify before the committee to ensure more timely responses going forward. If it does, then I suppose we will have to look forward to seeing you for a hearing every 30 to 60 days, and you do not want that. And they get worse over time! [Laughter.]

Thank you for continuing to make this a priority. Good communication between HHS and this committee is paramount to a good working relationship, and you understand that, I know that.

Now, let us talk about accountability. One of the big issues we discussed at your confirmation hearing was the absolute need for fiscal accountability given the huge breadth and scope of HHS's programs and budget. Overseeing them requires constant vigilance and effective management.

When looking at the size of the budget for HHS for this coming fiscal year, we see just how big your job really is. In fact, the expression "too big to fail" does not really apply here, as the HHS budget is so big one would argue that it is destined to fail.

The HHS budget for fiscal year 2016 is just over a trillion dollars. In real terms, if HHS were a country and its budget was its GDP, it would be the 16th-largest economy in the whole world. I think you have that chart over there that shows, where the red arrow is, you would be the 16th-largest economy in the world.

To put it in a more American context, the total budget of HHS is more than double that of Walmart and five times more than Apple. My concern is that the savings and efficiencies in the overall HHS budget are very small when compared to the overall spending. The President's proposed budget would save just under $250 billion over the next decade, which sounds like a lot, but that is only 3.8 percent of total Medicare and Medicaid spending.

More accountability is critical here to ensure that these programs have sufficient resources to continue to provide benefits for years to come. On the policy front, the administration needs to be upfront with Congress about their contingency plans if the *King v. Burwell* case is not decided in its favor.

Depending upon what happens in the Supreme Court in late June, HHS could have to figure out how to provide services for millions of Americans who are currently receiving tax subsidies that enable them to pay for health insurance. I can only assume that the agency has a plan in place for dealing with this possibility. Now, Secretary Burwell, I hope you will share that with us today.

That brings me to independence. For some time now, I have been concerned about the amount of influence HHS and the administration have over the operations and policies impacting the entitlement programs, certainly those run by CMS.

The budget released this week indicates that spending on just Medicare and Medicaid is expected to exceed $11 trillion over the next decade. In fact, CMS accounts for 35 percent of the total HHS

budget. These are astonishing numbers. They also reinforce for me something that I have long believed.

It is time to start talking about making CMS an independent agency apart from HHS. Nearly 20 years ago, Congress passed, and the President signed into law, the Social Security Independence and Program Improvements Act of 1994. That law separated the Social Security Administration from HHS and made it an independent agency.

At that time, SSA was the largest operating division within HHS and accounted for about 51 percent of HHS's total staff, and more than half of HHS's total annual budget. Now, I intend to introduce legislation to move CMS out of HHS. Whether or not CMS becomes an independent agency is something to consider going forward, but the accountability and transparency problems we currently see in CMS programs cannot wait.

I hope that we can work together in the coming months on both the Affordable Care Act and entitlement issues to create situations and solutions that work for all Americans.

Finally, I want to note that, while there is much in the President's budget with which I disagree, there are areas where I think we can find common ground. For example, I appreciate the provision in the budget that addresses the issue of over-reliance on congregate care facilities or group homes for children and youth in foster care. For years I have been working to call attention to the deplorable conditions in many of these group homes.

Recent research indicates that these group homes are unsafe, expensive, and too often contribute to profoundly negative outcomes for the children and youth who are placed in them. So I look forward to working with the administration to end the over-reliance on group homes.

Secretary Burwell, I look forward to your testimony today and to working with you to ensure that our most vulnerable citizens get the care they deserve. And I do appreciate how difficult your job is and appreciate the openness with which you have considered it with Senator Wyden, myself, and others on this committee.

[The prepared statement of Chairman Hatch appears in the appendix.]

The CHAIRMAN. Senator Wyden?

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator WYDEN. Thank you, Mr. Chairman.

Secretary Burwell, let me start by saying that my assessment is that you have set a new bar for Cabinet Secretaries in terms of reaching out and trying to be responsive. I hear about it with respect to citizens. Apparently, you are in virtually every corner of the country and taking your family. I can only imagine the challenge of that.

You are getting back to Senators. I hear Senators of both political parties, conservative, liberal, saying the Secretary actually got back to me. I mean, it is such a quaint idea that somebody would actually do that. Also, I understand you have discussions either coming or already begun with Governors. My sense is that you

have really set a new bar in terms of reaching out, and it is obviously very, very welcome.

Now, too many people in America, including millions in our country and in my home State, feel like they are falling behind. They just feel like, as the economy picks up steam, they are not getting ahead. It is our job to make sure that does not happen, and the Finance Committee has played a big role in this. It is almost like we are having a triple header this week. We had Mr. Koskinen in yesterday, you, and then Secretary Lew tomorrow.

The budget obviously articulates the priorities of today, but it also talks a lot about what our priorities are for the future, and we are looking forward to having you lay out how the proposal would strengthen Health and Human Services programs, promote economic mobility, and assist our middle-class families.

I do want to take a minute just to talk about where I believe American health care has been, and then talk briefly about where it is going. This year marks the 50th anniversary of Medicare and Medicaid, and a lot has taken place since those programs were created. The Congress came together to create the CHIP program, the program, of course, for children, and it has reauthorized it three times. The Congress has improved and expanded Medicare and Medicaid.

The Affordable Care Act makes access to high-quality care wider than ever. What I think is particularly important is, it has signaled that America is not willing to go back to the days when health care was for the healthy and wealthy. That is the way it was when you could go out and clobber the people with a preexisting condition.

Obviously, the job is not done, and so there is a twofold challenge, in my view: first, protect the progress that has been made, and second, clear the way for more progress in the future. For Medicare, that means guaranteeing that the program's benefits fully meet the needs of this era's seniors, and the demands on Medicare are clearly very different than they were 50 years ago.

The big-ticket Medicare costs of 2015 are no longer things like kidney stones and broken ankles. They are chronic conditions like cancer, diabetes, and Alzheimer's, and those conditions are tougher and they are more costly to treat.

The HHS budget, in my view, begins to acknowledge that reality, but clearly there is a lot more to do. Treating chronic disease, in my view, is the future of the Medicare program. So what is needed is a road map to efficient and effective care for chronic disease that boldly moves away from the outdated fee-for-service model. Patients and providers told this committee last summer about the need to address chronic care in a different way. There is bipartisan support for this in Congress, and I look forward to working with you and the administration to make that a reality.

Now, I was also thinking about the announcement last week about precision medicine, because this too helps to provide something of a road map for the future. Medical professionals understand that a treatment will often affect Susan in a different way than it affects George. And with the right research, it is going to be possible to learn what drives those differences and how to tailor treatments to fit an individual patient's needs.

The precision medicine initiative that is in the President's budget follows an innovative test program that was really created in this committee. It was part of our discussions. I do not see Senator Carper here. He has been very interested in that issue. But we have another big challenge, and the next step will be to design a payment system for this innovative field, precision medicine, that can do so much in the future for patients and for taxpayers.

The President's budget proposal also continues progress made by the Affordable Care Act to reward the quality of care rather than the quantity. The Congress can do even more by passing bipartisan, bicameral legislation to improve the way Medicare pays physicians, and Chairman Hatch obviously had a lot to do with putting that proposal together.

The President's proposal also takes a vital step by including 4 years of funding for CHIP. There are more than 10 million kids in America who get health insurance through CHIP, including more than 75,000 in Oregon. A child who starts life with quality health insurance has a better shot at a successful middle-class life than a child who does not. Renewing CHIP, in my view, is a no-brainer. Families and State agencies across the country are waiting for the Congress to step up and act on CHIP.

There are also steps that Congress can take to help guarantee that our health programs remain strong for generations to come. They are lifelines for countless Americans, and, as a result, millions of families will never have to choose between paying for a loved one's care and sending kids to college. Millions of Americans will grow up with access to quality care that keeps them healthy and out of the emergency rooms whenever possible.

Of course it is important to remember that the Department of Health and Human Services does a lot more than oversee Medicare, Medicaid, and CHIP. No department plays a bigger role in America's safety net. This committee has a long history of working on a bipartisan basis on policies to strengthen our Federal child welfare programs for vulnerable kids.

Just 5 months ago, the Congress enacted the Preventing Sex Trafficking and Strengthening Families Act. The Department is helping turn this bill from a piece of paper signed by the President into new tools that will help States move more vulnerable kids out of harm's way and into safer and permanent homes.

The President's budget proposal shows that it is possible to build on this momentum by expanding programs that keep kids and families together and healthy, with a special focus on getting involved early with vulnerable families. This includes programs like home visiting, which is especially important for first-time parents.

So, in effect, we are talking about multi-generational supports, and those can prevent the long-term costs associated with homelessness, abuse, neglect, and foster care. So we are talking about the people who are trying to get ahead in a tough economy and have just not seen the recovery make it to their neighborhood.

Thank you for joining us here today. We have a lot of opportunities, in my view, for working in a bipartisan fashion, and I will have some questions, but I do want to wrap this up by saying that, having been in public life and having worked with a number of Secretaries, I think, at the end of the day, there can be big differences

of opinion. But the only way you really make progress is by reaching out, and you have surely met that test. Thank you. I look forward to working with you.

Thank you, Chairman Hatch.

The CHAIRMAN. Well, thank you, Senator.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. Our witness today is Department of Health and Human Services Secretary Sylvia Mathews Burwell. Secretary Burwell has been leading the Department of Health and Human Services since June of 2014. Ms. Burwell has a long history of public-sector service, including most recently serving as Director of the Office of Management and Budget under President Obama.

In the Clinton administration, Ms. Burwell served as Deputy Director of OMB, Deputy Chief of Staff to the President, Chief of Staff to the Treasury Secretary, and Staff Director at the National Economic Council, all of which are very important positions. She also has extensive private-sector experience, including serving as the president of the Walmart Foundation, and before that as the president of the Global Development Program at the Bill and Melinda Gates Foundation.

Ms. Burwell received her AB from Harvard University and a BA from Oxford University, where she was a Rhodes Scholar. So we are honored to have you here and want to thank you for being here today. You can proceed with your opening statement.

STATEMENT OF HON. SYLVIA MATHEWS BURWELL, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary BURWELL. Thank you. Thank you, Chairman Hatch, Ranking Member Wyden, and members of the committee, for having me here today. I want to thank you for the opportunity to discuss the President's budget for Health and Human Services.

I believe firmly that we all share common interests, and therefore we have a number of opportunities to find common ground, from preventing and treating substance abuse, to advancing the promise of precision medicine, to building an innovation economy and strengthening the American middle class.

The budget before you makes critical investments in health care, science, innovation, and human services. It maintains our responsible stewardship of the taxpayer dollar. It strengthens our work, together with the Congress, to prepare our Nation for key challenges at home and abroad.

For HHS, it proposes $83.8 billion in discretionary budget authority, and this is a $4.8-billion increase that will allow our Department to deliver impact today and lay a strong foundation for our Nation for tomorrow. It is a fiscally responsible budget which, in tandem with accompanying legislative proposals, would save taxpayers an estimated $250 billion over the next decade.

In addition, it is projected to continue slowing the growth in Medicare. It could secure $423 billion in Medicare savings as we build a better, smarter health delivery system. In terms of providing all Americans with access to quality, affordable health care, it builds upon our historic progress in reducing the number of un-

insured and improving coverage for families who already had insurance. It extends CHIP for 4 years, it covers newly eligible adults in the 28 States plus DC that have expanded Medicaid, and it improves access to health care for Native Americans.

To support communities throughout the country, including under-served communities, it invests $4.2 billion in health centers and $14.2 billion to bolster our Nation's health care workforce. It supports more than 15,000 National Health Service Corps clinicians, serving nearly 60 million patients in high-need areas. With the funding streams ending in 2016, millions stand to lose primary care services and providers if we are not able to take action.

To advance our common interest in building a better, smarter, and healthier delivery system, it supports improvements to the way care is delivered, providers are paid, and information is distributed. On an issue for which there is bipartisan agreement, it replaces Medicare's flawed Sustainable Growth Rate formula and supports a long-term policy solution to fix the SGR.

The administration supports the type of bipartisan, bicameral efforts the Congress undertook last year. To advance our shared vision for leading the world in science and innovation, it increases funding for NIH by $1 billion to advance biomedical research and behavioral research, among other priorities.

In addition, it invests $215 million for the Precision Medicine Initiative, a new cross-departmental effort focused on developing treatments, diagnostics, and preventative strategies tailored to the individual genetic characteristics of individual patients.

To further our common interests in providing Americans with the building blocks of healthy and productive lives, this budget outlines an ambitious plan to make affordable, quality child care available to working and middle-class families with young children. It supports evidence-based interventions to protect youth in foster care, and it invests to help older Americans live with dignity in their homes and communities, and to protect them from identity theft.

To keep Americans healthy, the budget strengthens our public health infrastructure, with $975 million for domestic and international preparedness, including critical funds to implement the global health security agenda and its core strategies of prevention, detection, and response.

It also invests in behavioral health services and substance abuse prevention. It includes more than $99 million in new funding to combat prescription opioid and heroin abuse dependency and overdose.

Finally, as we look to leave our Department stronger, the budget invests in our shared priorities of addressing waste, fraud, and abuse, initiatives that are projected to yield $22 billion in gross savings for Medicare and Medicaid across the next decade. We are also addressing our Medicare appeals backlog with a variety of approaches.

Taken together, this budget advances our broader goals of making a 21st-century workforce, providing Americans with the building blocks of healthy and productive lives, and delivering impact that allows everyone to share in the prosperity of a growing America.

As I close, I want to assure you that I am personally committed to responding quickly and thoughtfully to concerns and communications from members of Congress. We have made progress, and we can do more.

I also want to just take a moment to thank the employees of HHS for their work on combating Ebola, for the work that they did assisting the unaccompanied children at the border, and for the commitment they show day in and day out, helping their fellow Americans obtain those building blocks of healthy and productive lives. I look forward to working closely with you to advance our common interests for the American people.

Thank you. And with that, I am happy to take your questions.

The CHAIRMAN. Well, thank you, Ms. Burwell.

[The prepared statement of Secretary Burwell appears in the appendix.]

The CHAIRMAN. As you know, the Supreme Court will soon decide the legality of IRS regulations that extend health insurance subsidies to individuals in States with Federal exchanges in the *King v. Burwell* case. The legislation itself, the Affordable Care Act, talks only about these exchanges being created in the States, so it is an important opinion. In my opinion, the regulations violate the Constitution's separation of powers by exceeding the executive branch's regulatory authority, but we will find out what the Court says soon enough.

At yesterday's Ways and Means hearing, Treasury Secretary Lew repeatedly refused to say whether the administration has a contingency plan if the Supreme Court rules against the administration. Secretary Burwell, does the administration have a contingency plan in case the Court invalidates premium tax credits and penalties in States with a Federal exchange? If you could say "yes" or "no," I would be happy.

Secretary BURWELL. Senator, right now what we believe is that the position that we hold, and that the Justice Department will represent for us in front of the Supreme Court, is the correct position. We believe that, both in terms of the spirit of the law and the intent of Congress, as well as the letter of the law. The Justice Department will make that argument.

In terms of what we believe and what we see happening, the idea that tax credits would be provided by the Congress for individuals in, say, the State of New York but not the State of New Jersey, is something that we do not believe that the Congress intended in any way, and we believe the letter of the law supports that.

The CHAIRMAN. There is a lot of indication that the Congress did intend that so that it would force the States to have to form the State exchanges rather than have the Federal Government do it for them. So it is a big issue, and the language is unambiguous, at least in my opinion. So I do not know what the Court is going to do, nor do I want to overly speculate on it. But assuming that the Court does find that the language is unambiguous and that only State exchanges can be formed, do you have a contingency plan?

Secretary BURWELL. Right now, Mr. Chairman, what I am focused on—I think everyone here knows that February 15th is the end of open enrollment. And in terms of providing quality, affordable access to health care, my deep focus right now is ensuring—

later today we will announce that there are 7.5 million people who have come in through the Federal marketplace, in addition to the 2.4 million who have come in through the State exchanges. Large majorities of those people are receiving the financial assistance that is being provided. Right now my focus is on completing and implementing the law, which we believe is the law. That is where my focus——

The CHAIRMAN. Then the answer must be "no," you do not have a contingency plan. That is all I am asking.

Secretary BURWELL. Right now what I am focused on is the open enrollment.

The CHAIRMAN. So that means you do not have a contingency plan. I would suggest that the administration ought to get one just in case. It is something that seems to me you are going to have to have because the possibility that millions of people will need coverage when this law runs out is important.

Well, let me ask you this. Has your Department communicated with insurers who participated in *HealthCare.gov* to plan for the possibility that the subsidies could become illegal? Have you made plans there?

Secretary BURWELL. What we continue to do is work with the insurance providers to implement the Affordable Care Act. We are working very closely with them as part of this open enrollment. One of our deep focuses has been the consumer. As part of that focus with the consumer, we have been working very closely with the insurers on making sure that we are focused on everything from how open enrollment works to providing tax——

The CHAIRMAN. But including this—I am more concerned about this issue right now. I am limiting my comments to this issue. I am sure you are working with the various States in every way you possibly can, but again, are you planning for anything if the Court decides the other way?

Secretary BURWELL. Senator, right now we are focused deeply on those issues that I have articulated.

The CHAIRMAN. All right. All right. Well, I have to say the insurers, to my knowledge, have not been given any guidance about what to do if the Supreme Court invalidates subsidies paid to them. So it is something I would hope that you will get on top of, just as a contingency plan, to make sure that you can handle these matters.

Now, Secretary Burwell, the ACA included more than $100 billion in appropriations. Over $1 billion of that money went to States that willfully and negligently spent Federal funds for development of a failed State exchange.

In your May 14, 2014 confirmation hearing before this committee, I asked you if these States would be required to reimburse the taxpayers. You said, "Where the Federal Government and taxpayers had funds misused, we need to use the full extent of the law to get those funds back," and I agree with you.

Has HHS recovered any of these funds, and do I have your commitment that you will take action on behalf of the American taxpayers to collect from the States the money that was, in the opinion of almost everybody, so negligently misspent?

Secretary BURWELL. At this point we have not received any of the funds. With regard to the funds, they are made in contracts, and we issue those to the States and then the States issue the contracts, so our grant-making to the States is the part that we have control over.

As part of that, though, a number of the States actually are taking action, both in Oregon as well as in Maryland. Efforts are being made in terms of the follow-up. The question of what the Federal Government can get back in terms of those funds is about whether or not, in the grant-making, that things were done that were not in line with the terms of the grant.

Right now, our Inspector General at HHS is looking into these issues to see if there are places where they think that has happened.

The CHAIRMAN. All right. My time is up.

Senator Wyden?

Senator WYDEN. Thank you. Thank you, Mr. Chairman.

Obviously, Madam Secretary, we are in tax filing season, and there are lots of issues with respect to the premiums and the credits. And obviously, Secretary Lew and Commissioner Koskinen play a key role. But you all are involved as well. I just have a couple of questions here.

Do you have any sense at this point of how many people might be entitled to a refund under the law, because that is certainly one possibility, and how many people might owe something? Do you have any sense of numbers there? Because that is what I am being asked.

Secretary BURWELL. We do have a sense that over three-quarters of people will just check a box. Those who have existing insurance in terms of when they file, three-quarters of people will just check a box.

With regard to the other category, the one that you are referring to, which is those who have been in the marketplace and whether or not they have under-paid or over-paid with regard to the subsidies that they have received, we do not have a sense, because this is the first time through. We have consulted with our colleagues at the IRS, and, because it is the first time through, I am sure both Commissioner Koskinen as well as Secretary Lew have spoken to that.

Senator WYDEN. What are you all doing to make sure that this is consumer-friendly for people who are going to have to wrestle with these issues?

Secretary BURWELL. We have worked together—the Department of Health and Human Services, the Treasury Department, and the IRS—to make sure that we are getting information out as much and as quickly as possible. With regard to those who will be filing in the category that you were just describing, 91 percent of those filers use some type of software to file.

So within the software, it is incorporated just as everything else is incorporated, and we have worked to do that. We have been working with the tax filing organizations, whether that is at the end of the H&R Blocks or down to the Volunteer Income Tax Assistance Centers that I think many of you know, which are those centers that help lower-income people.

So we are in close communication. Secretary Lew and I have done calls with the VITA centers, Secretary Lew has done calls with the tax preparers, and we are in constant communication, because we want to make sure that the questions they are getting, we understand, so that we can provide help in answering those if we can.

Senator WYDEN. Let me move on to the chronic care issue, which, as you and I have talked about, I think is the future of Medicare. I look back at the days when I was director of the Gray Panthers, and we talked about broken ankles. Nobody is talking about a broken ankle now being something that drives Medicare's future. It is about diabetes and cancer. And you all run a number of programs that hope to, for the future, address the concerns of the chronically ill.

When can we expect to see some of those results? I know that you have programs that you would like to see look at a variety of different conditions. The challenge, of course, is you have this horribly fragmented delivery system, and that is one of the things legislators on this committee are trying to change, and trying to change in a bipartisan way.

But tell me about the programs you all operate that target the chronically ill, which I think is going to be the future great challenge of American health care.

Secretary BURWELL. With regard to the chronically ill and the things that we do at the Department, it actually cuts across various parts of the entire Department. There is the work that we are doing as a payer in Medicare and Medicaid, and we are working on innovation in that space. We are working on innovation with the States through the State innovation model grants, where we are granting money to a number of different States to try innovations in terms of some of those things. In the Medicare space, we see the work that we are doing in the Innovation Center.

With regard to when we will know—as you all know, the legislation gave us conditions that said you cannot decrease quality or increase price—we are measuring those as we go forward. I would also mention that in these areas of chronic care, there is also the work that the CDC is doing. And some of this is about prevention, and we think for some of these conditions such as diabetes, heart disease, and some of those, it is about prevention. CDC plays an important, strong role as we go forward with that.

Senator WYDEN. Let me ask you about the Precision Medicine Initiative and, again, what we are looking at for the future. I think this too is a key part of the future of Americans' health care. I think for families to have confidence that, when a loved one gets sick, their treatment is going to be targeted and precise based on their genetic make-up, this is pretty important. This is about as important as it gets for a family.

But if we are going to tap the potential of precision medicine, the big payers—and your Department runs several of those programs—Medicare and Medicaid and private insurers, are going to need to pay for it. I know you are just getting started in this area, but what progress are we making in terms of setting up payment systems? That is what this committee tried to do in the Affordable

Care Act: to make sure that you can actually get paid for tests and innovation and these kinds of services that really help patients.

Secretary BURWELL. I think that the question of payment also gets to the announcement that I made last week. For the first time, we as a government are committing that we have set a goal for ourselves to change the way that we are paying in Medicare. We have set the goal that we will have alternative payments, payments that are based on value instead of volume.

We have set the goal for 2016 of 30 percent of those payments, and by 2018 of 50 percent of those payments. As part of our moving forward to alternative approaches to payment, I think that is where we are going to try to bring in some of that innovation.

The other thing that I think is important as we consider cost in this space is that this type of an approach to medicine hopefully can work for the individual, because you can treat in ways that may not be as costly, as you were talking about in your earlier question.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Grassley?

Senator GRASSLEY. Thank you, Madam Secretary, for appearing. More importantly, I appreciate very much the frequent phone calls; you call me and give me updates.

I only have one subject, one question at the end, but I have a lead-in, so be patient, please. I am concerned about the recent failure of CoOpportunity, a co-op created through the Affordable Care Act operating in Iowa and Nebraska. CoOpportunity was one of 23 co-ops formed under that law, and the Federal Government loaned money to them through CMS.

As I understand it, CMS played a significant role in overseeing the co-ops, including having ultimate authority over setting the rules. CoOpportunity was very successful in attracting beneficiaries and had the second-most covered lives of all the 23 co-ops. It was even more successful than they had anticipated.

In the summer, it became obvious to CoOpportunity and the Iowa Insurance Commissioner that CoOpportunity would need additional loans from CMS to stay in business. Both the Iowa Insurance Commissioner and CoOpportunity frequently inquired with CMS about their capital position and the need for certainty ahead of open enrollment, as it was clear that a liquidity crisis was developing. CMS knew CoOpportunity was going to be in trouble if it did not get loans.

CoOpportunity was allowed to be in Iowa and the Nebraska marketplace when it opened on November 15th. CMS finally let CoOpportunity know that no further loans would be coming, right before Christmas, and the Iowa Insurance Commissioner was forced to take over CoOpportunity December 24th.

I am concerned about CMS's role as a regulator of CoOpportunity, and then of all co-ops. There was about $2 billion of taxpayer money loaned that depends on the success of the co-ops for the Federal Government to get its money back, but CMS did not distinguish itself in its actions with CoOpportunity.

I will have more questions for you for the record regarding CMS's action, but my question for you today is on behalf of Shane

and Betty Bush, Milford, IA, just as an example of some people who have real problems because of CoOpportunity's bankruptcy. They paid their premiums and renewed their coverage with CoOpportunity, as they expected it to be there for them in 2014.

Unfortunately, Shane Bush had emergency surgery January 3rd. Fortunately, Mr. Bush is recovering, but the care was not inexpensive. The Bushes have already hit their out-of-pocket maximums for CoOpportunity. With CoOpportunity being liquidated, the Bushes will have to find new coverage, and that next insurer will not have to recognize the money already spent by the Bushes in 2015. With additional expenses certain this year, the Bushes will be out of thousands of dollars they have already spent in 2015.

Madam Secretary, the Bushes cannot afford to pay out-of-pocket premiums for two different plans. They are in this situation, as I see it, because CMS ignored the warnings from Iowa and CoOpportunity, allowing CoOpportunity to go back on the marketplace. Now folks in Iowa and Nebraska like the Bushes face financial consequences because of CMS's foot-dragging.

I intend to ask you further about what CMS was doing and why, but what I want to ask you today is what responsibility you think your Department and CMS have to people like the Bushes. I think they had about 100,000 people whom they were doing business with.

Secretary BURWELL. With regard to the issue of the consumer, that is our number-one priority as we work with the State Insurance Department in Iowa, as we work through this. And so the consumer is the number-one priority, and we are thinking through what authorities we have and what we can do to help support all of those consumers like the family that you have just described.

As we have worked through this, I think as you know, Director Tavenner has been in touch, and we look forward to responding to the questions that you have sent us in your letter, and any others that you add to that list. But we are focused on the consumer.

One of the things that has happened through the evolution of this, the co-op process, is from the legislation that was passed and the amount, there were many, many rescissions in terms of the amounts of money that we had to do additional support. So at that point in time, it came down to a very limited amount. There were rescissions; sequestration took additional dollars; ATRA* took dollars out of these funds. We are concerned. Right now our focus is deeply on the consumer, so we look forward to working with the State of Iowa, which has the main authority over this, to figure out ways that we can help those consumers.

Senator GRASSLEY. Thank you, Madam Secretary.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Stabenow?

Senator STABENOW. Thank you very much, Mr. Chairman.

Welcome, Madam Secretary, and thank you very much for the hard work of you and your staff on a complicated, critically important set of issues. I think we need to first underscore the good news. The latest CBO projections show that more and more people

*The American Taxpayer Relief Act of 2012.

are finding full-time work. We want to make sure that it is work where you can work one job and be able to care for your family, that they are getting access to affordable health care.

We know that fewer Americans are going into bankruptcy because of medical crises. That is important. Tax credits are helping people afford coverage. People who have insurance are able to get new opportunities to get preventative care and vaccinations, wellness visits. And frankly, folks who have been paying into health care for a long time are finally guaranteed they are getting what they are paying for, and they cannot get dropped if they get sick, and they can find insurance coverage for a preexisting condition, and so on, and so on. So, all good news.

I would say that, because of the importance of health care to the people of Michigan, as somebody who was around and deeply involved in the debate on the affordability of health care and being involved as one of the chief supporters of what I call the affordability tax credits—in fact, at the time, the chairman introduced me as Senator Affordability, which I carry as a badge of honor.

But I would say, just for the record, that the affordability tax credits are working as we drafted them, as we intended them for all Americans, not just some Americans. And if in fact they went away or the entire bill, the law was repealed—we have now seen a bill introduced here in the Senate that has been brought immediately to the floor with, I believe we have 47 Republican cosponsors so far. This would be serious for families in terms of no longer having access to the protections of affordable health care and access to health care.

What I would like to ask you about, though, is one piece of that that unfortunately went from being a part of the comprehensive plan to being optional State by State, which has undermined seniors' and families' ability to be able to get affordable health care, and that is Medicaid.

When we put all this together, we assumed—and we know that 80 percent of the money in Medicaid is low-income seniors in nursing homes, so we are talking about seniors in nursing homes—that low-income seniors in nursing homes and their families would be able to get the help under Medicaid that they need. In Michigan, more than 500,000 people have enrolled in the Healthy Michigan plan. I congratulate our Governor and others who put that together. We still have time to go on this.

So, when I look around this panel, we have 11 States represented in the Finance Committee that still have not provided access for low-income seniors to nursing home care, or to families and children, through the expansion of Medicaid.

I wonder if you might speak to what is happening to families and the costs even to States, and certainly our hospitals. I know in Michigan folks were talking about the number of people coming to the emergency room, getting care the most expensive way possible, rather than getting it through a doctor and so on in a way that is better for them and contains costs.

Could you talk about what is happening because States are not giving access to families and seniors to health care through Medicaid?

Secretary BURWELL. I think the impacts of Medicaid expansion have to do both with the individual as well as economic impacts. In terms of the individual impact, in terms of the health and financial security, yesterday when we had folks at the White House who had written the President, there was a woman who actually went onto the marketplace, because she thought she would pay a fee. She went onto the marketplace, found out actually she was not in the marketplace but was Medicaid-eligible. She went in to see a doctor, had never had a history of breast cancer in her family, ended up actually having a mammogram because it is part of what is covered, and found out that she had breast cancer. So that is for the individual, for the individual in terms of that financial security, the ability to pay for and have health care. So that is for the individual.

Economically, what we see is, in the States that have expanded Medicaid, there are fewer rural hospital closings, an issue that is affecting a number of States across the country. That has to do with the reduction in indigent care costs, and that is what we do see in those States. We see anecdotal evidence in terms of what is happening in communities where more of the care is being paid for. So there are benefits on the individual side in terms of financial and health security, and then with regard to the States themselves, they are seeing those benefits I just mentioned.

Senator STABENOW. So it is a major rural health issue.

Secretary BURWELL. It is a rural health issue, but it is also happening in urban hospitals, because generally, in some urban areas, there is one hospital—not always—but there is often the one hospital that tends to take care of that indigent care. So the economics of that entity can be dramatically affected. We know those are the direct impacts. The indirect impacts are for everyone else in terms of premiums. When there is less indigent care, there is less pressure on premiums for those who are even in an employer-based system.

The CHAIRMAN. Senator Schumer? Thank you, Senator Stabenow.

Senator SCHUMER. Thank you. Thank you, Mr. Chairman. Thanks for holding the hearing. And I want to thank you, Madam Secretary, for the great job you do. You are a star.

First, ACA, despite all the naysaying, has some huge successes. Health-care spending growth has decreased significantly. That is huge in terms of not just health care itself, but our budget: $600 billion dollars less through 2020. The uninsured level is the lowest in decades: 9.5 million insured in my State of New York. We have really done a good job. I salute our State. Our health exchange, the New York State of Health, has signed up 2 million people for low-cost health coverage. Eighty percent of those enrolled said they were previously uninsured, so it is great.

Now I have—and I appreciate the emphasis you have put on research, early learning, and your support for CHIP. I am now sitting in the seat where Senator Rockefeller sat for a long time, and I am mindful of CHIP all the time.

I have two questions for you. The first is on graduate medical education, a place where I oppose the administration strongly and vehemently, and I cannot even understand your logic here. The

President's budget says Medicare payments to teaching hospitals for costs of Indirect Medical Education exceeded the actual patient care costs, and they want to correct this imbalance by reducing the IME payments by 10 percent. That is an enormous cut: $16.3 billion.

Now, your budget proposal recognized that we have a physician shortage, and we do. If we are going to insure more people, we need physicians. It is one of the places that ACA did not really do the job in terms of filling the gap of new physicians that we need, and it sort of adds insult to injury to now cut the payments to teaching hospitals. They are just not going to teach as many medical students and make them doctors if you are going to cut this.

I believe that current funding levels are critically important to maintaining a state-of-the-art environment, not only training doctors but training the best doctors. We do not need a majority of our doctors to be trained overseas, but that would be the direction in which you are headed. So it seems to me counterproductive to attempt to train more physicians by cutting teaching hospitals that train them. How do you reconcile that?

Secretary BURWELL. With regard to the issue of making sure that we have enough care in the country and the specific GME area, what we are trying to do is make sure that we balance the needs, and our proposal also targets funding, and additional funding, for those who go into primary care and specialties where we have shortages.

The proposal that we are trying to craft and come forward with is a proposal that affords us the opportunity to have fiscal responsibility and keep the slots, but there is the question of the payment of the slots, indirect versus direct costs, and then we add additional funds that would help do targeted efforts.

In addition, with regard to the broader issue, and in terms of some of the things we do do, the National Health Service Corps is a place where there are large investments in the budget to try to make sure that we are supplementing primary care. We have also proposed the extension of the Medicaid primary care funding, so we are trying to make sure that we are working on the health resources.

Senator SCHUMER. Well, I think you are robbing Peter to pay Paul. I certainly believe in the programs you have mentioned. They have been around for a while. They have not filled our need. What we have proposed, a bunch of us, and it has bipartisan support, is to increase the number of slots and allocate half of that increase to primary care. It seems to me a much better and tested way to go than say, well, we are relying on these new programs which have never filled the gap. Having said that, I just wanted you to know I am vehemently opposed to that proposal, and I hope the administration would reconsider, if you have not understood my language until now.

Secretary BURWELL. I look forward to working with you.

Senator SCHUMER. On Ebola, I want to thank you. The CDC has done a great job. We knock government all the time, and, if you read the media the first few weeks, you would think everyone was going to get Ebola. The number of cases here in America has been, thankfully, few. The number of cases in the three hot-spot coun-

tries has declined. That just did not happen by magic; it happened by great work at the Federal, State, and local levels.

In New York, our hospitals did an amazing job. Forty-seven percent of the people who flew into this country from the three Ebola countries landed at Kennedy Airport, and our city, State, and Federal Governments all got together and made sure that we did not have the situation that we had initially in Dallas. So I thank you for that and for the good job you do.

But can you just tell us—I know we have put some money in, and I worked very hard to have a provision, with the help of many of my colleagues, that our hospitals in and around the country would get reimbursed for the huge outlays they have had to make. Many of them had to create anti-contamination rooms, they had to buy equipment, they had to do training. Can you provide us with how you plan to ensure that the Ebola treatment centers—I care especially about the ones in New York—receive appropriate reimbursement?

Secretary BURWELL. We are working to have those funds reimbursed. We are working to have a contractor that will help us do that reimbursement on a hospital-by-hospital basis. In addition, States and communities will receive other funding for the preventative work that they did, so there are special funds for the treatment hospitals like Bellevue, which did a tremendous job in New York, and the others that did treat patients around the country.

We look forward to continuing to work on this, and we are very appreciative of the funds and want to move them as quickly as we possibly can to get reimbursement to those treatment hospitals and to help those hospitals that got ready and prepared.

Senator SCHUMER. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Roberts?

Senator ROBERTS. Well, thank you, Mr. Chairman.

And, Madam Secretary, let me echo the sentiments of many members to thank you for the job that you are doing.

During your confirmation hearing, we talked a lot about the Affordable Care Act's Independent Payment Advisory Board. The acronym is IPAB. Sort of reminds me of Pablum that people do not want to eat. So anyway, IPAB.

You said, and I will paraphrase here, that you were hopeful IPAB never needs to be used; it can only be triggered in the window when you will serve as Secretary. Your estimate said it will never be activated. You were hopeful that we can make sure that IPAB never gets triggered, and we all agree.

But here we are again with a budget request where you are acting to expand this authority to find savings. How can you explain how you went from hoping it never had to be used to now doubling down on IPAB and expanding the savings it must find?

Secretary BURWELL. What we are trying to do is get to the core of what IPAB was about, which is making sure that we can work together to continue to keep the costs down in Medicare and in the entitlement space. We are working to do that with our proposals.

We have seen, just in the period from 2010, our Medicare spending is $116 billion below what it was predicted to be. On a go-

forward basis, that is why we have the proposals in our budget, to keep moving that out. The proposals that we have in our budget extend the life of the trust fund by 5 years.

Our objective is to actually put in place specific policies that will continue to move out that time frame, and we are hopeful that we can work with the Congress to get those policies enacted, to continue the entitlement savings. We have some savings from the last years in terms of what we are seeing, but we want to continue on a path to tight and contained growth with regard to that spending.

Senator ROBERTS. Well, I think everybody wants to contain the growth, but I do not want rationing. I am very worried about the Independent Payment Advisory Board, the CMS Innovation Center, the U.S. Preventative Services Task Force, and the Patient-Centered Outcomes Research Institute, all well-intended. I have labeled them The Four Horsemen of Regulatory Apocalypse because of all the rationing.

Now, wait a minute. You are depending a lot on something called a RAC, and that is a Recovery Audit Contractor. I must tell you that when the contractors ride into town in western Kansas, the doors shut and everybody hopes that nobody, no RAC person, comes and knocks on the door. I think they put hospital administrators on the rack, if you will.

I appreciate that you have included a number of proposals in the budget to help address the appeals process, because you go into a hospital, and they have a choice. You either pay the fine—and contractors get gold stars if you have fines—and then you say that is savings with regards to Medicare. It is also rationing.

So here is the point. CMS presented a settlement offer, and over 2,000 hospitals entered the process. Chief Administrative Law Judge Griswold noted that, as of July last year, there were 800,000 pending appeals. My question to you: if all of these hospitals would complete the settlement process, how many claims would potentially be cleared from the backlog? Are we even making a dent?

Secretary BURWELL. The issue is one that I think many of you on the committee know is one that I am deeply concerned about, which is why we have reached out and talked about this issue, certainly before today. With regard to how many will come through settlement, they will not all be cleared out that way.

The strategic approach we are taking is threefold to address what I agree is an extremely important issue. It is an issue about balancing those who are not—it is about program integrity, because there are people who are not doing things that we as taxpayers would pay for.

Senator ROBERTS. I understand that.

Secretary BURWELL. At the same time, in dealing with the concerns that you have articulated in terms of how it feels and how the process is used, we are using three strategies. The first is to use administrative tools like the one you articulated. The second is, there is funding needed so we can clear out the backlog. Judge Griswold and others can process those. But it is a specialized person that we need to do that.

And then the third is, there are legislative proposals that we believe will extend our ability to both get rid of the backlog and prevent it in the future. We have had conversations, especially with

this committee—and we appreciate those conversations—and we have included the seven proposals in our budget so that we could be specific in working with you all on how we can do that, because, to be honest, it is going to take all three for us to get rid of that backlog.

Senator ROBERTS. I appreciate your response. I am not sure that I am following you on all of the details in terms of the specifics, and we would like to do that. I know you are extremely busy, but we will make that inquiry. I just have to tell you that when you have RAC contractors racing around to the rural health care delivery system, they are not very welcome. It seems to me they do not trust the hospital administrator or the doctors, or the whole delivery system. In return, these rural folks do not have any trust in government, and that is not a good thing. So, let us work together to see if we cannot get a better situation.

Secretary BURWELL. I would like to do that and would like to have follow-up with you on this issue.

Senator ROBERTS. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Cornyn?

Senator CORNYN. Good morning, Madam Secretary. On December 17th, a number of Senators sent a letter to you and to Secretary Lew about the *King v. Burwell* case, and I would like to follow up on Senator Hatch's questions because you did not answer a single one of them about the contingency plans and notices to people who might lose their taxpayer subsidies for their health care.

Let me just start by asking, has HHS taken steps to inform all current Federal exchange enrollees about the *King* suit and how a ruling against the administration might affect them?

Secretary BURWELL. We have not, Senator. We believe that we are implementing the law as it is intended to be implemented, and as we do that, that is what we were talking about with the consumers who are entering into the marketplace.

Senator CORNYN. And my question is, if the administration loses, have you taken steps to advise Federal enrollees about the consequences that may apply to them as a result of the administration losing that lawsuit?

Secretary BURWELL. Right now, as I mentioned with the chairman, what we are focused on is what we believe is our responsibility: to implement the law as fully as we can, to focus on the consumer experience, and we are working for that February 15th deadline.

Senator CORNYN. And that is not an answer to my question, Madam Secretary. You are a highly intelligent, charming person, but you refuse to answer our questions and that, to me, does not strike me as trying to work with Congress but rather contempt of Congress's oversight responsibilities. So let me just ask you, if the administration loses the *King v. Burwell* case, do you plan to ask Congress for additional legislation?

Secretary BURWELL. With regard to that question, we are now at a stage where even oral arguments have not been made, Senator, in terms of the case.

Senator CORNYN. And that is not my question. My question is, if you lose, are you going to come to Congress and ask for additional legislation?

Secretary BURWELL. With regard to the issue of legislation and the Affordable Care Act in its entirety, what we have always said and what we continue to say is, with regard to things that will improve the Act, we are open, whether that is the recent vote for veterans—and I know that members of this committee actually have bills that have to do with our firefighters and that would enact into law what we have done through administrative actions. We will work with the Congress. How we will judge what we work on with the Congress is, does it increase access, affordability, and——

Senator CORNYN. Madam Secretary, you are not answering my question. My question is, if the administration loses the *King v. Burwell* case, do you intend to come to Congress and ask for additional legislation to address that decision by the Supreme Court?

Secretary BURWELL. Senator, we believe that the position we hold is the correct position, and——

Senator CORNYN. And my question is, if you lose, if the Supreme Court disagrees with you, will you come to Congress and ask for additional legislation?

Secretary BURWELL. Senator, what we know right now is, it would be devastating, the effect, in terms of loss of premium, loss of individuals. What we are focused on right now, though, is implementing the law that we have before us, and that is our focus for now.

Senator CORNYN. So you are going to ignore the Supreme Court decision in July. So let me ask you this. Since you will not answer my question about a legislative solution, do you believe that your agency has authority to make an administrative fix to the law?

Secretary BURWELL. Senator, as I have said, what I have focused on is, right now, the current implementation of the law. That is a question in terms of——

Senator CORNYN. And what I am focusing on is, if the administration loses—and so far you have refused to answer my question, and notwithstanding your earlier statements that you want to cooperate with Congress and this committee and you respect our constitutional oversight responsibilities, what I do not understand is why you continue to refuse to answer the question.

So let me ask it again. If the administration loses in the *King v. Burwell* case, do you believe you already have the authority to make an administrative fix, or will you come to Congress and ask for additional legislation?

Secretary BURWELL. Senator, I am focused right now on implementation. With regard to those questions, we believe that we are right in implementing the law and that the law will stand.

Senator CORNYN. I am asking, if you are wrong, if the Supreme Court disagrees with you—if five members of the Supreme Court disagree with you—do you believe you have authority to issue an administrative fix, or do you think you need additional legislation?

Secretary BURWELL. And with regard to the answer to that, Senator, what I am saying is, what I have been focusing on is implementation, not on that question.

Senator CORNYN. Mr. Chairman, Secretary Burwell is a charming person, and she is obviously intelligent, but these hearings are absolutely no use to us if the witnesses refuse to answer straightforward questions, which this witness has repeatedly done. I am not sure exactly what the proper solution is to this, Mr. Chairman, but I would like to visit with you about that, because it seems to me that this administration continues to parade witnesses in front of committees like this one and to deny us a straightforward answer to a straightforward question. That is just unacceptable.

The CHAIRMAN. Yes. Well, Senator Wyden would like to comment on this whole matter.

Senator WYDEN. Mr. Chairman, I just want to make clear what I think today is all about. Today is about the HHS budget, this multi-billion-dollar budget that involves millions of Americans. That is the topic at hand. I am very interested in working with my colleagues on the other side of the aisle on health policy. I have shown that plenty of times, and so have my fellow Democrats. But I think the idea this morning that we are going to ask a witness to speculate about a court case, to speculate about something hypothetical, and in effect have a big debate about something, I think misses the point of the challenge at hand.

The challenge at hand is about the budget, and I hope that we can figure out a way over the course of the morning—we have plenty of colleagues who still want to ask questions—to talk about the topic that was scheduled, and that is the budget, and not talk about hypotheticals, about something else. By the way, this is not the Department of Justice's budget, this is the Department of Health and Human Services'. I hope we can stay on the budget and not get into some recitation about a parade of hypotheticals and speculations. Thank you, Mr. Chairman.

Senator CORNYN. Mr. Chairman, if I can just respond to the ranking member. It is the same question you have asked, Mr. Chairman. We are not limited as Senators to what the topic of the hearing is. We can ask questions, any questions we want, about the agency that this witness is responsible for administering.

To come here and repeatedly refuse to answer the questions strikes me as nothing less than contempt of our oversight responsibility, and it is a very, very serious matter. I am just really, frankly, shocked that this witness would take that position. I just find it unacceptable.

Senator WYDEN. Mr. Chairman, just to continue this briefly, to say that this witness is handling this committee with contempt misses what members on both sides of the aisle have been talking about for weeks. This official at HHS has reached out to this committee, the people of this country, in an unprecedented way, and I think arguing that because she will not talk about hypotheticals, speculate about a court case, means that she is handling this Congress with contempt, I just think is way off-base.

The CHAIRMAN. Well, both Senators are entitled to their opinion.

Let me just ask this question. Have you made any recommendations, as the premier department that handles all these matters that are so important to the administration, as to how they would handle it if, as Senator Cornyn has raised, the case goes against the administration or against the Affordable Care Act?

Secretary BURWELL. Senator, with regard to where I am now on the issues that I am focusing on, whether it is Ebola, the measles, or——

The CHAIRMAN. No, wait, wait, wait, wait, wait.

Secretary BURWELL. I am focused right now on implementation.

The CHAIRMAN. We got that point.

Secretary BURWELL. So——

The CHAIRMAN. Look, wait a minute. These are not stupid people up here, and you are not stupid either. Why don't you just say that it is up to the President and the Justice Department, and that would get you off the hook, it seems to me.

Secretary BURWELL. Right now——

The CHAIRMAN. It does not solve the problem, because you should be recommending what should be done, because that is a serious problem.

Secretary BURWELL. With regard to, as you are clearly articulating, the Justice Department is the next step——

The CHAIRMAN. Well, why don't you say that?

Secretary BURWELL [continuing]. In terms of what the administration is doing. The Justice Department will represent us.

The CHAIRMAN. I get tired of bailing out you Democrats all the time, you know? [Laughter.]

That was supposed to be humorous. I did not think it was. [Laughter.] I thought I was being quite funny. But I have this subtle sense of humor that sometimes does not come across.

Senator WYDEN. Mr. Chairman, just to wrap this up, I do not think the Secretary needs any bailing out. We have something called a Judiciary Committee where they can have discussions about speculative matters involving the Supreme Court.

The CHAIRMAN. I think——

Senator WYDEN. I just hope we can handle the budget today.

The CHAIRMAN. Well, let me just say I think Senator Cornyn is certainly within his rights. I think his comments are accurate comments. Ms. Burwell just continues to answer that she is not focused on this. I understand that. Then tell us who is focused on it, because it is an important thing that can just throw you into all kinds of turmoil, and we are concerned about it. It is a legitimate concern of this committee. To make a long story short, I think Senator Cornyn raised a very, very important issue, as have I.

We will now go to—who is next? Let us go to Senator Coats.

Senator COATS. Well, first of all, I want to second what our members have said, Madam Secretary, that your engagement and accessibility have set a new standard, and I think we all appreciate that. I do not know when you sleep, but I know how active you have been and will continue to be.

Secondly, though, I wanted to second what the chairman and Senator Cornyn and others have said, not to ask you the question again, because I think I know what you are going to say, but to say that we all know that this health care proposal enacted in 2010 has been one of the most impactful pieces of legislation ever enacted by this Congress, by any Congress, and it affects tens of millions of Americans directly in terms of their health care, which goes right to the essence of who we are as human beings.

Clearly, there is a collision, potentially, coming with the Supreme Court decision. It is probably not likely, given the President's very clear admonitions about how he will not accept any piece of legislation that modifies this in any significant way through a repeal and replacement, but there is a potential collision coming, and it would be irresponsible for the administration not to have a plan to address that, should the decision not come down the way you would like.

I do not have a question here, it is just a statement affirming that it would cause great chaos and be totally, I think, irresponsible. Somebody ought to be looking at, what do we do if, and that is what the question here is.

Now, I want to thank you personally for your engagement with our current Governor, Governor Pence, whom I was with this morning. He wanted me to pass on his thanks also to you for 2 years, almost 2 years, of engagement over a request for a waiver for the State of Indiana. Our former Governor, Governor Daniels, put into place something called the Healthy Indiana plan, and it was innovative, it was creative, it has been proven to provide health care for a number of Hoosiers.

Governor Pence wanted to expand that, and there are 350,000 Hoosiers who will benefit—at minimum—from your agreement to work with us and come to a conclusion. There are some really innovative reforms here on traditional Medicaid, and I think some of them are the first ever.

So I think it is important for our State to be responsible in playing this out the best we can to prove that these innovative solutions can be a benefit to all Medicaid recipients. In that regard, I would just like to have your assessment of some of the first-of-a-kind proposals that you have agreed to that hopefully will prove their worth and can be duplicated perhaps in other States or throughout the system: the co-pays and the patient participation; the patient option to choose a plan if it better meets their family needs; the contribution to the so-called Power Plan, which is a modification of health savings accounts; and the State's referral process to every individual who applies for job training and job searching through State sources.

It is all combined in this new plan, and we are pretty excited about it, but I would like to get your thoughts on it here, I think for the benefit of the members of the committee and for others who are looking at ways to provide better access, better health care at lower cost.

Secretary BURWELL. I am pleased that we were able to come to agreement and work with the Governor, and I was happy to do that. One of the first things I did when I became Secretary was meet with the National Governors Association to express my willingness to work on a State-by-State basis to use the waiver process to do two things: one, to do agreements that would be, on a State-by-State basis, what a State needs in terms of continuation, and moving on building on the Healthy Indiana plan for Indiana. In other States, Utah, Tennessee, there are other approaches that are important to those States.

The second thing is that I think what you are reflecting is, waivers are a means by which we can try and we can test things to find

out if they are things that work and then move to how we would scale them as a Nation if they do work.

We are looking forward to working with the Governor as he moves to implement, and we tried to make sure that he could implement quickly as soon as we reached agreement, and we look forward to finding out, what are the kinds of things that we can do better in Medicaid as a program? That effort in the waivers is accompanied and complemented by something that the National Governors Association asked us to do, which is State innovation model grants.

And so, at the time that we are trying things, we are also doing innovation in terms of payment models and helping the States through financing the States to do that, and a number of States have received grants. There is a first round and a second round.

Senator COATS. Well, I know our Governor in our State and those who have participated in this, including the health care providers and their participation and contributions to the program. We have a lot at stake here, and we hope to be able to deliver to you innovative, successful solutions. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Cardin?

Senator CARDIN. Well, thank you very much, Mr. Chairman. Secretary Burwell, it is a pleasure to have you before our committee, and thank you very much for your leadership and service to our country in this very important role under challenging circumstances.

I want to talk, first, about an issue that I am working on with Senator Blunt dealing with community mental health services. There is a challenge for people who are suffering from severe depression or anxiety disorder getting the type of help they need in a community setting. If they go to their primary care physician, as many of them do, there is lack of capacity in that office to deal with their needs. If they go to an emergency room, it is a very inefficient way and most likely inadequate to take care of their needs.

There have been some demonstration programs dealing with a collaborative care model, where the primary care person can get help from a mental health specialist so that you use better community services to keep people healthy in their community—less costly, better services. There are obstacles in the way under Medicare and Medicaid for this collaborative care model, and I just would welcome your thoughts on how we can work together to try to expand these opportunities, removing those obstacles and offering incentives for a collaborative care model that will provide better services at less cost for people who have mental illness.

Secretary BURWELL. So the issue of behavioral health and the payment for behavioral health is one of the tools that we think we have. And working to make sure that payment occurs in a way that is equitable with payment for other types of care is something that we are working on, and certainly we would welcome the opportunity to have a conversation with you, having had conversations with Senator Stabenow as well as Senator Blunt. So I would love to continue those conversations.

I think, as you know and have mentioned, we are also focused on how we can do more community-based care. That actually touches also upon the delivery system reform, which we had a little bit of a conversation about earlier, so that we are creating home health systems and that there is communication between physicians, because that is sometimes one of the missing links in behavioral health.

Senator CARDIN. Well, we would be interested as to what you can do under your authority, but if you need congressional help particularly, let us know what obstacles need to be addressed by Congress and how we can expedite the implementation of better collaborative care models in our community. I appreciate that.

As you know, I have a particular interest in NIH funding. I was pleased to see that the President's budget did increase NIH funding by about $1 billion. I would like to see a larger number. The returns are incredible from what we invest, and I think this is a bipartisan interest.

One of the centers, the Institute of Minority Health and Health Disparities, is one that I take pride in that Congress created under the Affordable Care Act. They received a slight increase, from $259 million to $281 million. Can you just share with us your commitment to NIH funding, but specifically how you see the Institute of Minority Health and Health Disparities functioning under your leadership?

Secretary BURWELL. The issue of minority health disparities cuts across actually the entire Department, and NIH has been an important part of that effort. With regard to minority health disparities, they are great in our country, and there are a number of ways that we believe we should address them.

Working through NIH with regard to how we think about research, and the research on the science that is creating these disparities, is how I think about that particular piece, as well as NIH's role in making sure that we have minorities who are part of the system, both in terms of physicians who are practicing in a clinical setting, but actually researchers who are part of the process who come from these communities.

At the same time, we are focused deeply on probably the most important thing we can do to reduce these disparities, which is addressing the disparity in coverage. That is something I think you know that we focus on as well.

Senator CARDIN. Absolutely. If you could keep me informed on the progress, not only at the National Institute but at the different offices for minority health, I would appreciate that.

Lastly, let me just put on your radar screen pediatric dental coverage. We have been watching its implementation. Quite frankly, it has been more seamless than what we originally were concerned about. There are more universal policies that are being offered that handle pediatric dental coverage rather than stand-alone plans. As you know, in Maryland, with the loss of Deamonte Driver in 2007, it has been a particular issue, pediatric dental care.

So I would just urge you to monitor how the private market is working on offering coverage for pediatric dental. Since it is a required coverage, we want to make sure that in fact it is being

taken advantage of by those who have gotten coverage through the exchanges.

Secretary BURWELL. Thank you, and we will. I had the opportunity actually, as I was out traveling the country, to meet with a woman who took her child to the dentist for the first time as part of coverage.

Senator CARDIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman.

Secretary Burwell, thank you so much. I read a *Bloomberg* article that I would like to enter into the record, and the headline was: "U.S. to Overhaul Medicare Payments to Doctors, Hospitals." So that was music to my ears. And then the first paragraph or so said, "The Obama administration makes historic changes to how the U.S. pays its health care bills, aiming to curtail the costly habit of paying hospitals and doctors without regard to quality or effectiveness." Then it goes on to say it ". . . will tie billions of dollars in payments to how their patients fare." So actually all that was a quote from that news article I want to enter.

[The article appears in the appendix on p. 256.]

Senator CANTWELL. So first of all, that is music to our ears in the Pacific Northwest and any State that already is making its way down the system of more efficient care that is focused on the patient. The fact that the administration is setting this goal of 30 percent of traditional Medicare payments to alternative payment models by 2016 is just a terrific goal, and 50 percent by 2018. As you know, we worked very closely on the Medicare value-based modifier as a way to make sure that we are focusing on quality, not on quantity.

So my question is, in the details of that 30 percent, one of the things that we have had discussions about here is, what does the incentive look like? I want to make sure that we are not setting a big goal of having 30 percent shift over to that, but having the incentives be so small that we are not really changing behavior.

So people have talked about things like 4 percent, or a bonus, or penalty caps, but we want to see good behavior being rewarded and bad behavior being discouraged. So what can you tell me about, within the 30 percent, how aggressive we can be?

Secretary BURWELL. I think that there are a number of different things that can help us get there, and some of those are about incentives and some of those are about approaches: bundled payments as a type of approach in terms of how we go about doing it. There are things like the value-based approach where you are rewarding good behavior, and, for those who do not have that behavior, they will take a hit for doing that.

I think there are tools like that that are being used. We are seeing that the private sector and the providers are moving towards this care because it is better quality care and more affordable for them. And we have received help and support, and there has been legislation, about helping us as we are doing Accountable Care Organizations.

There are some places where we may need additional flexibilities as we are learning about what people react to with regard to incentives. So that is a place specifically where I think we would like to work with the Congress to make sure that we are able to do that.

The other thing I would just say is that the pressures in the private sector right now, they are also helping us, because private-sector payers are moving in this direction, whether it is Boeing that is partially in Seattle and how they are negotiating their payments—those examples are making a difference to us.

Senator CANTWELL. So you think the incentives could be more than just a few percent?

Secretary BURWELL. I think the question of exactly what the numbers are depends on which incentives you are using and how, so I think the details here matter for a number of the institutions. So I think it is a balance.

Senator CANTWELL. Well, what I am saying is if, by 2016, you can say that 30 percent of traditional Medicare payments are at an alternative model, but they are only shifting 1 or 2 percent, that is not interesting to us because we are already there. We are efficient, and we are penalized all the time for our level of efficiency.

So we want the country to move as fast as possible to that new model. It saves money, it is better care for the patients, and we do not want to lose doctors in the Northwest just because they get paid less because they are more efficient.

We hope that behind the 30-percent number are incentives that really move people. Some of the previous discussions we have had here of the Camp-Baucus bill—basically you are going to move at a glacial pace. Even though you could say you had 30 percent in the new system, they would be moving so slowly you are really just continuing to reward bad behavior.

Secretary BURWELL. There is a secondary goal that I do not think is covered in the article and that we have not had the opportunity to discuss, and that is that any payer—so there are really, we think, two classes of folks: folks who are moving at the non-glacial pace, and those will be those who are moving to full alternative payment models.

Then we also set a second goal, and that is about how the percentage of any payment that anyone is doing would move to 85 and 90 percent over time. So we actually have set up goals that are trying to encourage the speed in a larger group, but accounting for the fact that there are those—and this will probably be a conversation in rural areas and other places where people are slower to move.

Senator CANTWELL. Well, I look forward to discussing that with you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Brown, you are up.

Senator BROWN. Yes. Thank you, Mr. Chairman. And thank you, Madam Secretary, for your focus on implementing the Affordable Care Act and what it has meant to the literally hundreds and hundreds of thousands of people in my State and your State of West Virginia, your original home State of West Virginia.

I want to talk to you about the Children's Health Insurance Program. I have spoken with Chairman Hatch about this and Ranking Member Wyden. Chairman Hatch was one of the small number of authors of this bill in 1997. We know what it has meant. The uninsured rate among children in 1997 was 14 percent; today it is 7 percent. We know other things about CHIP. We have modernized it. It works in its present form very well today.

In my State it covers 130,000 children. Most of them are sons and daughters of working parents, but they fall in a place where they just were not getting health care because those parents do not have insurance and do not have the income to make those decisions to send their children to a family doctor for preventive care, and other things.

I have several letters here, Mr. Chairman, if I could enter them in the record, and I ask unanimous consent to do that.

The CHAIRMAN. Without objection.

[The letters appear in the appendix beginning on p. 51.]

Senator BROWN. Thank you. These are letters from 40 Governors, including my Republican Governor John Kasich. Forty Governors, both parties, have written to this committee to stress how critical the current CHIP program is to their States and the need to extend funding now rather than later.

Senator Casey and Senator Stabenow on this committee have been particularly helpful in this effort. The majority of State legislatures, as we know, finished their sessions within the first few months of the year. Twenty States will adjourn in just 3 months. More than half will have adjourned by June 1st of this year. Congress needs to act swiftly to avoid any disruption in children's coverage.

As you know, this bill, this law, is authorized up through 2019, but the funding runs out in September. That is the push and the urgency for State legislatures. Just comment on, if you would, the impact on States if we do not extend the funding of the new CHIP, the current CHIP the way we do it now, if we do not extend that funding soon.

Secretary BURWELL. I would just reflect on my former role as the head of OMB, as one trying to manage a situation where you did not have predictability of funding, whether that was in the form of a shut-down or another form. In terms of trying to manage against that, it is very difficult to manage, especially in the space of health care where there are contracts and providers that must be paid.

So the urgency, what you are articulating from a management perspective for the States, is extremely important. And I think that is what is reflected in the letters that you have in your hand. In terms of the conversations with the States, the States need to have this predictability, and it is an important source that they depend on in terms of providing health care for their populations, especially for their vulnerable children.

Senator BROWN. Thank you.

There are few things that this committee works on, a few important major things, that have had the history of bipartisanship that CHIP has. Again, 40 of the 50 Governors support it. A number of people here have voted on this legislation. Some have been around as long as I have and voted on it in 1997. A number of them have

voted for reauthorization. It has passed this body's House and Senate overwhelmingly.

Let me shift to a second issue in my last minute and a half: the Medicaid primary care parity provision in this year's budget. A study published in the *New England Journal of Medicine* found that parity in payment over the past 2 years has led to an increase in appointments for Medicaid patients.

Unfortunately, the provision that authorized this parity in payment between Medicaid and Medicare expired a month or so ago at the end of 2014. Senator Murray and I introduced the Insuring Access to Primary Care for Women and Children Act, which would have extended this payment parity for 2 more years. We were not able to enact that so far. Can you comment on the importance of this provision in the President's fiscal year 2016 budget proposal?

Secretary BURWELL. As you are reflecting, we have included it in the President's budget, because we think it is important. It comes down to one of the issues that we discussed a little bit earlier, which is this question of provision of primary care.

As we expand the number of people who are covered, making sure that we translate access to actual care and better health and wellness is what we are aiming to do. We believe that this is a provision, based on the analytics that we have seen, that can help us move forward on making sure that there is enough care, and appropriate care.

Senator BROWN. Is there a way to use the success of this provision to help guide future conversations and policy decisions around Medicaid payment reform in the future?

Secretary BURWELL. I think all of these pieces and parts—and whether it is the results that we see here in terms of having people become a part of the system of providing that care, and knowing that many people in Medicaid self-report that they have quality care that is accessible and makes a difference to them, that kind of step in terms of this provision, as well as the kinds of things that Mr. Coats was mentioning in terms of some of the reforms we are doing—I think it is an important program. It is a cost-effective program. We need to continue to look for the ways to make it more effective, both in terms of the quality and the cost.

Senator BROWN. Thank you, Madam Secretary.

Thank you, Mr. Chairman, very much.

The CHAIRMAN. Thank you, Senator.

Senator Heller?

Senator HELLER. Mr. Chairman, thank you. I appreciate the opportunity to have this discussion. I want to thank, also, the Secretary for being here.

But I do want to raise a point of order, listening to the discussion that you had with the ranking member and also with Senator Cornyn. I guess I am a little confused. Again, as a newer member of this panel, am I limited in the scope of questions that I can ask witnesses?

The CHAIRMAN. No, there is no limitation. There may be some questions raised from time to time, but no limitation.

Senator HELLER. It was my understanding that if it is a speculative question, based on the ranking member's comments, that spec-

ulative questions are for the Judiciary Committee or for some other committee other than this.

The CHAIRMAN. I think these questions were proper for this committee.

Senator WYDEN. Mr. Chairman, just on this point, I think it is somewhat ironic that Senators file a brief challenging the law on what I consider to be completely unfounded grounds, and then demand that the Secretary explain how she plans to avert the disaster that will occur if their brief is successful, if they win. Now, we can sit here and debate, because I am like a lawyer in name only. I was director of the Gray Panthers, so I do not pretend to be a good lawyer. But I do think that we have a huge challenge in terms of getting on top of this budget.

The Senator from Nevada is a thoughtful person, and I am really looking forward to working with him in a bipartisan way on these issues. I just hope this morning—what a quaint idea—that we will focus on the topic at hand, which is the budget. We can keep speculating and have this parade of hypotheticals. As the chairman noted, we do not bar people from asking questions, but I do think there is a little irony, as I noted there.

The CHAIRMAN. Well, let me just add that these questions are legitimate because they affect this Department more than any other Department, and I was asking whether there are any contingency plans. I mean, that is a normal question.

Senator HELLER. Mr. Chairman, I agree with you.

The CHAIRMAN. And I understand that you may not have any control over this at all in this administration.

Senator Heller, I will add a minute and a half to your time.

Senator HELLER. Thank you. I agree with you. I agree with your questioning, and I also agree with Senator Cornyn's questioning. The reason I bring it up is, we are going to have Treasury Secretary Lew in front of us tomorrow, and if economic models and interest rates are not all speculative, I just want to make sure that I am not limited to the kind of questions that I can ask the Treasury Secretary. But I will go forward.

Madam Secretary, I want to talk a little bit about the Medicare backstop. You received a letter last week from Senator Rubio, if you will recall that particular letter that came to your office. I also sent a letter to your predecessor on the same issues. As you are probably aware, the budget proposal would reduce the bad debt payment from 65 percent to 25 percent.

Now, in Nevada we have 38 community hospitals. They handle almost 250,000 annual admissions. There have been more than 2.7 million outpatients just last year. I am particularly concerned for America's, and in particular Nevada's, rural hospitals, many of which already operate on a very thin margin in order to provide care to these patients.

So I guess, given the issue, I am troubled by the administration's continued effort to significantly cut bad debt payments. I am also concerned this will have a very real impact on Nevada's hospitals and our senior population. If you would, please, could you share your justification for this particular policy?

Secretary BURWELL. Senator, I care deeply about rural America and these issues of rural hospitals. As I am sure you can imagine,

every time I have meetings, these are some of the questions I ask. Overall in the budget, in terms of how we support rural America in the areas of health care, there are a number of investments, and whether that is the community health centers, which disproportionately help rural America, or our investments in health care providers for rural America, there are a number of things that support that.

With regard to this specific question of this provision, as we work to do something that I think you and others have said is a priority—which is long-term change in terms of structural reforms to entitlements so that we work on that long-term deficit—what we have tried to do is put together a balanced approach that both has effects on beneficiaries and has effects on providers.

When we make the decisions and choices about what we include, we try to do that on an analytical basis. In this case, we are trying to be parallel to what is happening in the private sector in terms of how they treat this issue. So we are working to make sure that we are appropriately supporting rural communities, a very important thing, the health care in those communities and the economics of that.

But this is an issue that is a part of our broader approach to making sure that we are addressing the long-term entitlement issues, which we look forward to working on with the Congress. If there are ideas, approaches, and specific policy changes that others believe are better than ours with regard to the package we have, we look forward to hearing those specifics.

Senator HELLER. Thanks for the answer. I would suggest that there is probably a real problem in some of the rural hospitals outside of the State of Nevada, but I just want to go on record, Mr. Chairman, that I do vehemently oppose these cuts. I do not think it is an issue that is going to go away anytime soon. So I remain concerned, but I hope that we can continue the conversation at a future time.

Secretary BURWELL. And I would welcome the alternatives and ideas about how we should address these long-term entitlement issues.

Senator HELLER. Thank you. Thank you.

I have one quick question, and that has to do with the projected savings in your budget. Last year you projected over $414 billion over the next 10 years in savings, but this year it has been reduced to $250 billion. Can you explain why the proposed savings are so much less this year than compared to last year?

Secretary BURWELL. Two reasons. One is that some of the savings, as we go year-by-year, we are getting some of the savings in terms of the previous year, but it is also because we have proposals in our budget. One of the proposals on the mandatory side, which we net out so the number is a net number instead of a gross number—the gross number still is $423 billion—but we decided that we would put in place investments.

Those investments are mainly in the area of early learning and the idea of child care, and the idea that for working Americans and people who are up to about 200 percent of poverty, that it is almost $10,000 a year to have your child cared for. If you have a child who is between zero and 3 and you are in that income bracket, we be-

lieve we want to encourage work and we want to encourage family. So by helping with this child care issue, that is where the bulk of some of those investments is made, so we made a choice.

The CHAIRMAN. All right. Thank you, Senator.

Senator HELLER. Thank you.

The CHAIRMAN. Senator Bennet?

Senator BENNET. Thank you very much, Mr. Chairman. Thanks for holding the hearing.

Madam Secretary, thank you for your responsiveness over the last years. I appreciate very much the focus that precision medicine has in this budget and in the President's address to the Congress. In my home State, the University of Colorado launched a large-scale effort last year across six hospitals, including our children's hospital, around precision medicine. I think we ought to do more to encourage the development of life-saving therapies and ensure that they come to market. They are important to both patients and the broader economy.

Senators Hatch, Burr, and I worked on expediting the approval of these types of breakthrough therapies at FDA in 2012. Since 2012, this pathway has now successfully led, Mr. Chairman, to 19 new breakthrough approvals, and 55 more are in the pathway. So I wonder whether you could talk about why this is receiving the emphasis it is in the budget and what the NIH and FDA plan to do to collaborate with universities and the private sector to help spur the development of these breakthrough therapies or precision medicines.

Secretary BURWELL. So in terms of the why and the emphasis on it, as you are saying, there is a lot of energy and effort that is already underway in the private sector. In terms of the why, I think it is for two fundamental reasons. First, we believe it can dramatically change how we provide health care to individuals in this country.

The second reason is that we believe that this type of innovation and this type of cutting-edge research should be here at home, it should be in the United States, and that we should make the commitment and make the funding available to make sure we are supporting this research, because we believe that is part of keeping our economy an innovation economy.

With regard to how the FDA and the NIH are going to work together on these issues and work with the private sector, first I want to express appreciation for the support that we have received in terms of those FDA numbers that you have given. We are moving to try to move things through faster. You see that 19 and the 55 coming. NIH and FDA are both going to be working together and working with the private sector.

One of the things it will mean to get the precision medicine to work and be right is that data and information from those entities in Colorado will be incorporated in the thinking, and so it is going to take close partnerships. The million-person study that we are talking about, we will be working on closely with the institutes. We are actually getting input on how we structure it up front, so organizations like those that you talked about in Colorado, we look forward to hearing from.

Senator BENNET. I think I should make two important points just to quickly respond to that, then I have one other question. It proves, I think—to the people around here who say, all is lost all the time, we cannot improve anything, it is a disaster at the FDA—that has been the go-to place for people who want to innovate, both in the agency and outside the agency. We ought to be doing more of that as we think about what we are doing going forward.

Second, as you point out, this is about keeping American jobs here and American innovation here and driving an economy that is actually lifting the middle class. That was why we got into that work to begin with, and it is actually working. So it is a reminder that sometimes we can actually move beyond rhetoric and accomplish something in a bipartisan way that has meaningful results.

Last week, Senator Grassley and I, along with a number of our colleagues on the Finance Committee—Senators Nelson, Portman, and Brown—introduced the ACE Kids Act of 2015. This bill would improve how Medicaid coordinates care for our Nation's sickest children and seeks to reduce the burden on families who often have to travel across State lines for their children's care.

As you know, children who have complex medical conditions make up roughly 6 percent of the children in Medicaid but account for up to 40 percent of the program's costs. This issue is especially challenging given that Medicaid is largely a State-run program and these children often need highly dedicated care in multiple States where certain specialists live.

Given HHS's recent focus on alternative payment models and the move away from fee-for-service, I just wanted to ask you whether you had had a chance to look at that legislation, whether your staff might be able to work with us to provide the necessary technical assistance to get this bill over the finish line.

Secretary BURWELL. We look forward to working with you to understand how we can address that issue that I think you are articulating, which is, because Medicaid is State-based, how do we make sure that that care is both high-quality and affordable across State lines?

Senator BENNET. Thank you. Thank you, Madam Secretary.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you, Senator Bennet.

Senator Scott?

Senator SCOTT. Thank you, sir. I appreciate it very much.

Madam Secretary, it is good to see you again. I certainly enjoyed talking to you yesterday as well, and I do appreciate your responsiveness to the questions from Senators. You have certainly established a positive reputation as it relates to getting back with us. It is obvious that you care about having a healthy relationship with Senators, and I hope my comments do nothing to take away from that.

I will say that every dollar that we spend that we do not have is taking money from a youngster, a young person who cannot afford a lobbyist, a young person who cannot afford to bear that burden, taking her future earnings without her permission to use today and leaving her with a bill that is utterly burdensome and a system that is broken as well.

When I think about Obamacare, I think about the fact that it started off in 2009 at a cost of around $900 billion in the estimate. CBO then changed that estimate to $1.8 trillion. Then recently we have seen it go back down to about $1.35 trillion by year 2025. It started with about 45 to 47 million Americans uninsured. By the year 2024, according to CBO's estimates, we will still have 31 million Americans uninsured after spending $1.3 trillion at least, maybe $1.8 trillion, or maybe they will change the estimate again.

At the same time, we are squeezing the health care providers to a place where they simply cannot afford to provide care to some of the patients who desperately need the assistance. So having a card on the front end but having no one to take care of you on the back end does not seem like progress, as well as still having 31 million Americans uninsured.

One of the reasons why I think you have had so many questions about what happens in the *King v. Burwell* case is because, when you look at the actual law itself and the construction of the law from a financial perspective, with 31 or so changes to the law, delays to the law, we find ourselves unprepared for a future that obviously is coming, it seems like to me.

A couple of questions. I would like to go back to the *King v. Burwell* question. You are a brilliant woman, without any question. You have served very well. I think I voted for you when you were up for OMB, so I have a lot of confidence in your capabilities.

I remember the conversation that we had in the office. You were on the MetLife board of directors. I cannot imagine a member of a board talking to your CEO and asking him a question about the possible scenario, maybe a probable scenario, that there may be something that happens that will require the company to be prepared for an outcome, a legal outcome, and the answer is, "I do not have a plan." I just do not see that as a realistic outcome. The question I have heard over and over again is simply, is there a contingency plan—not what is the plan, but is there a plan?

Secretary BURWELL. Senator, with regard to—and I think we have been through this—right now in terms of this issue of planning for a hypothetical for which there have not even been oral arguments in front of the Supreme Court, what we are spending time on, and what I am spending my time doing is focusing on what I believe I am responsible for, which is implementing the law that you all have given us as I understand it. That is where, right now, my time is focused.

Senator SCOTT. So you have no margin at all to spend any time focused on a probable outcome that could impact the delivery system of health care in America? You have no time for a contingency plan whatsoever?

Secretary BURWELL. Right now, with regard to the issue of a probable outcome, as I think I have said, I think we believe that the position that we hold is a position that both represents the letter of the law, for one—and I will let the Justice Department articulate the reasoning around that—and we recently wrote in the brief that we filed with regard to the letter of the law, that certainly in the spirit of the law, the idea that the U.S. Congress gave tax breaks to people in New York but not people in New Jersey or other States is untenable. We believe that in terms of the issue—

you used the word "probable." We believe that we are in a position that is the right position.

Senator SCOTT. So section 1401 of the law specified that people may receive a premium tax credit if they enroll through an exchange established by the State under section 1311. So you believe that there is no likelihood that the actual letters in the law will have weight in the Supreme Court?

Secretary BURWELL. With regard to the issue of the specific arguments around the letter of the law, I am not a lawyer, and I will defer to my colleagues at the Justice Department with regard to the specifics of that, and we have filed a brief.

Senator SCOTT. So, no contingency plan.

Secretary BURWELL. As I have said, right now what I am focused on is what is before us now in terms of the most important responsibility, to implement the law in a way that serves the consumer. Between now and February 15th, that is my deep focus.

Senator SCOTT. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Casey, at last you are next.

Senator CASEY. Mr. Chairman, thank you very much. Secretary Burwell, we are honored you are with us today. Let me say at the outset that I have been in State government and the Federal Government now for what I guess is about 18 years. I know competence and integrity when I see it; I think you have demonstrated that in this job, and I think you have demonstrated that today.

I want to start with a list, and I will try to do these quickly, because there is a lot to be positive about, not just in your statement and in the budget presentation, but also the impact of the ACA and other policies. Let me do this very quickly, and then I will raise a point of contention. But I do want to ask you about Medicaid—a couple of questions about Medicaid.

First of all, with regard to the newly insured since ACA, just a staggering number of Americans now are covered. I do not have the exact number, but we are into the double-figure millions, and that is significant. Next, the President's proposal to extend funding for the Children's Health Insurance Program for an additional 4 years: I was heartened and encouraged by the proposal.

Just to give you a sense of what my State of Pennsylvania has, right now we have, as of January, 147,464 children enrolled. Our program is a little more than 20 years old, but I do not know what we would do without the program. So Senator Brown and others who have raised this issue repeatedly as I have, we are heartened, and we just hope that your commitment to it, the administration's commitment to CHIP, will be shared by people in both parties.

I noted in another document the donut hole savings since 2010—meaning seniors who have to pay out of their own pocket when they hit a prescription drug gap—the reversal of that has meant savings of $11.5 billion, affecting more than 8 million seniors. Eight in 10 customers in the Federal marketplace are getting coverage for a hundred bucks when you factor in the tax credit.

Next, funding for the National Institutes of Health: I appreciate your commitment to increase funding for that, and I believe that it should be bipartisan here, and I hope it will continue to be. Early learning: I do not have time to go into that, but I would like to note

a great commitment by the administration. Hospital readmissions are going down, literally saving lives. According to your testimony, if you look at 2010 to 2013, hospital readmission reductions saved 50,000 lives and $12 billion in health spending.

Child care: the commitment there is great. We will not have time to go into that. Head Start, Early Head Start, home visiting, rooting out waste and fraud—there is a long list of positive investments, and I think we should not only celebrate or note those achievements and commitments that I itemized, but we should fight very hard here to support funding and any other legislation to reach those goals.

I wanted to ask you, though, about Medicaid. The way I look at Medicaid is, it is really the program for long-term care for seniors, children, and individuals with disabilities. So instead of thinking of the program, I try to think about who gets the benefit of a great program. I am unalterably opposed to any block-granting of Medicaid. It is a really bad idea, but worse than that, it would be harmful to people.

I wanted to ask you, in light of this debate about what happens to Medicaid, what happens to the—in our State, by one estimate—about a quarter of a million seniors who depend upon Medicaid for long-term care? What happens to those seniors? What happens to the children in this country—by one estimate, more than 30 million kids—if we go in the direction of block-granting Medicaid?

Secretary BURWELL. We believe that a block grant is something that is harmful to those individuals because one of two things happens: it is either harmful to the individuals or harmful to the States in terms of if we have an economic downturn, a change in the way care is provided.

What will happen is, without the flexibility to respond to that, the beneficiaries will suffer. That is where the cuts will go in terms of meeting the numbers. Either that will happen, or it will go onto the State's balance sheet, so we believe that is not a good approach to doing this.

As you know, we are working with States on waivers and innovative approaches, but we believe that that is an approach that—the reason we do not like that approach is because of the damage it can do to beneficiaries, as well as to States, potentially.

Senator CASEY. Well, I appreciate that. I know my time is running out. I will raise two issues and do most of it by asking for written follow-up.

One is, children's hospital graduate medical education. We have three hospitals that have been very dramatically impacted: the Children's Hospital of Philadelphia, the Children's Hospital in Pittsburgh, and St. Christopher's in Philadelphia. I have a basic disagreement with the administration on this. We still have the program in place. I was hoping for a much more significant commitment beyond the $100 million. I think we are getting great results for our kids because of that program, and we will talk more about it.

I will submit a question on that, as well as, now that I am out of time, the proposal regarding treatment foster care, also known as therapeutic foster care, for giving foster parents the kind of specialized training that they need to take care of kids who have par-

ticular challenges. But I will do that by way of a written question. But thank you for your testimony. Thanks for being here and for your service.

[The questions appear in the appendix.]

Secretary BURWELL. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Menendez?

Senator MENENDEZ. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for your service. I would like to, in a very short period of time, see if we can cover four topics: (1) the challenge of Medicaid enrollment in New Jersey; (2) IP protections on biologics; (3) autism coverage; and (4) the 2-midnight rule. First of all, before we go to that, I just want to highlight a couple of key components of the President's budget proposal that I believe are critically important for the health and well-being of the most, in my view, important part of the American population, and that is children.

These are the home visiting program and the CHIP program. His budget calls for a very welcome $15 billion investment in voluntary evidence-based home visiting, which has proven highly successful in helping pregnant women, new mothers, and their babies.

The budget also calls for a full extension of the CHIP program, which has proven unmatched in extending health care to children throughout the country. I strongly support these programs, and I hope the committee works to extend them as soon as possible. I look forward to working with you on that.

On the Medicaid enrollment question, there is a serious and ongoing issue in New Jersey of an estimated 44,000 Medicaid applications backlogged and still waiting to be processed. Now, I believe you were in New Jersey recently. You may have heard about this issue firsthand. Because of the backlog, people in the State are either unsure of their coverage or are foregoing care. It seems to me fundamentally wrong that if people are eligible, that they are prevented from getting the health care while their eligibility is being determined.

So when I have asked this question before, I was told that CMS was considering measures to address it, both carrot and stick approaches. Has CMS taken any administrative actions to push States to clear their backlogs, and what about measures to require States with significant application backlogs to provide applicants with at least provisional coverage until their application is fully completed, which is what a judge in California ordered to be done?

Secretary BURWELL. Senator, I will have to go back and check, because my knowledge of the number—my understanding is, we are at a much lower space from the 44,000. That is something that I want to go check on, because my understanding is, with regard to our 2014 backlog, that we are almost through that backlog.

I want to come back on that specific issue because it relates to the second part of your question. The work-around that we have done with the State of New Jersey in using the Federal marketplace to process things—and it is a flat file—is the technology we are using to do that. We are through that, and we are very close to full automation on the front end for 2015. So I think I need to make sure that our numbers——

Senator MENENDEZ. Well, I hope that is the case. It would be welcome news.

Secretary BURWELL. Yes. If our numbers are——

Senator MENENDEZ. But that is not my understanding——

Secretary BURWELL. And so I want to go and make sure.

Senator MENENDEZ [continuing]. In dealing with different entities on the ground. All right.

New Jersey is home to some of the world's leading medical researchers, who work every day to advance innovative biologic therapies to combat disease and illness. In order to guarantee that progress that often provides for both cost savings and life-saving, life-enhancing drugs, we need intellectual property protections.

I have difficulty in understanding how the administration calls for a reduction in the patent protection for innovative, complex biologics from 12 years to 7. When your fellow Cabinet member, the U.S. Trade Ambassador, was here, he was telling me that they are fighting robustly to keep the 12-year patent exclusivity on the biologics prevailing in trade agreements.

So I do not know how he does that if we domestically are seeking to undermine that, so have you been engaged with the Trade Department on this particular question?

Secretary BURWELL. Yes. And my understanding is that it is not yet settled with regard to where we will be in TPP.

Senator MENENDEZ. No, I understand that. But the question is, if you come here and say we should reduce it from 12 to 7, and he is negotiating with countries saying we should retain it at 12, isn't that a fundamental flaw in our bargaining position?

Secretary BURWELL. With regard to the specifics, this is something I will follow up on with the U.S. Trade Representative. The administration's position is that we believe, as reflected in our budget, that we should go to 7.

Senator MENENDEZ. All right. Well, that is something that we would have a real problem with.

Finally, autism coverage. When you were in your confirmation hearing, we talked about this. I would like to know—I am hearing from families who come to realize that their plans lack or restrict these benefits, which is not what the law calls for. I want to know whether HHS is doing everything to ensure all critical autism services, including applied behavior analysis, are in all qualified health plans. I keep hearing from families that that is not the case.

And secondly, on the 2-midnight rule, I just want to say this is something that Congress voted to delay for a period of time as a result of last year's SGR bill. I do not get a sense that much has been done with CMS and the hospitals, physicians, and Medicare recovery contractors once the delay is lifted, in terms of dealing with this question. Maybe you can inform the committee.

Secretary BURWELL. With regard to the 2-midnight rule, what we would like to do is actually work with the Congress to make sure that we can improve on that. The issue of medical judgment, which is one that has been raised with us in terms of the problems around that rule, is something we would like to have a conversation about. As you stated, there are statutory concerns, in terms of what we are doing. I think what we would like to do is have the

conversation so that we can move forward and do it in a way that reflects medical judgment.

With regard to the autism issue, I just wanted to touch on that briefly. What CMS has done is moved to have definitions that will make it clearer, and hopefully that will help. I think, as you know, the States are implementing the essential health benefits and quality benefits. So the step we believe we could take and did take was to try to get clearer definitions with regard to those issues in autism.

Senator MENENDEZ. Mr. Chairman, on the 2-midnight rule, I will just point out that the extension that the Congress passed ends at the end of next month. So unless we have the wherewithal to figure out a way of moving forward, we are going to have a problem again.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Portman? Let me see, is that right? Senator Portman—all right.

Senator PORTMAN. Thank you, Mr. Chairman. I appreciate it.

And, Madam Secretary, thank you for being here. Because my colleague, Mr. Menendez, just talked about the 2-midnight rule, I have to say that I share his concern over it. And look, I spent time with rural hospitals back home, spent time with some urban hospitals, and they just do not get it. It penalizes some of our beneficiaries.

We have to come up with a common-sense way to address hospital inpatient and observation stays. You are creating, by promulgation of these rules—you are incentivizing behavior that is actually going to cost us more in the end, so I hope you will work with us on that.

I want to talk about three other things if I could, quickly. One is substance abuse, the second is Medicare Advantage, and the final one is the budget, since that is what we are here to talk about.

With regard to Medicare Advantage, I have a strong concern about the way in which there is a bias in the current way we are evaluating the program. A little background on this: yesterday I sent a letter to CMS, which was copied to you as well. Senator Nelson and I, who is on this committee, co-authored it, and we got 40 of our colleagues to sign up, including 21 members of this committee on a bipartisan basis.

We made the very simple point that Medicare Advantage is working. In Ohio, 38 percent of seniors are on it. More than 20 percent of those seniors, by the way, are either dual-eligibles or other low-income seniors, so-called special needs cases. Our satisfaction rate is 85 percent, so people like this program. It provides them a comprehensive health care program, integrated care, disease management that everybody talks about, and this has been shown to lower costs and improve patient care.

So Medicare Advantage is something that is working in my State, and seniors like it, and yet CMS has this way that they are evaluating the various health care programs that has a bias with regard to our Medicare Advantage plans, in part because we do take care of so many dual-eligibles and low-income seniors.

CMS claimed recently that it has taken steps toward recognizing this problem through a Request for Information analysis from MA plans that demonstrates this bias. So I would want to bring this to your attention, but also ask you if you have any thoughts today, quickly, on what are the agency's plans for releasing the results of that analysis so we can see it, so it is transparent, and for implementing a solution to this problem.

Secretary BURWELL. With regard to—we agree Medicare Advantage is working. We believe that the changes that have been put in place over a period of time have been effective, as you are reflecting, whether it is the fact that 99 percent of beneficiaries have access, or that the percentage of 4-star plans has gone up to 67 percent, or that we have seen an increase in the number of people enrolled. So we agree the program is working.

With regard to the specific——

Senator PORTMAN. Let me just say if I could, just for a second, that people understand what you are talking about. If you get a rating that has too few stars, then the plan can go out of business. That happened in Ohio. We had a plan that was serving a lot of low-income seniors that was actually run out of business by this evaluation, so it is very important to get the evaluation right. Sorry.

Secretary BURWELL. It is important to get the evaluation right. We appreciate the Congress's support in giving us money to do studies on the question of the socioeconomic impact of these measures. We are working through that, through the analysis we have been given, and there are two places that that is focused: one is Medicare Advantage and the other is readmission.

But we know we cannot wait on that analysis, so we are continuing, through CMS's regulatory process, to look at the issues you have raised with regard to, how does the population you serve impact these ratings?

Senator PORTMAN. All right.

With regard to substance abuse, thank you for your willingness to put in the budget a comprehensive look at what is a growing problem in my State and around the country, which is opiate addiction. Prescription drugs less so, now more heroin, which is less expensive and causing a huge problem.

The number-one cause of death in Ohio today is heroin overdoses. It has now surpassed traffic accidents. The comprehensive strategy has to include prevention, it has to include treatment, it has to include recovery, and it has to include some new and innovative medical interventions to try to deal with the treatment and recovery side. So I thank you for that.

As you know, Senator Whitehouse and I have proposed legislation to address these issues in a comprehensive way. We would like to work with you on that. We would love your help on that to try to get some more co-sponsors and try to get that to the floor, but I think this is a problem that for too long we have kind of swept under the rug, and it is time to deal with it in a comprehensive way.

Secretary BURWELL. I appreciate your leadership and have publicly recognized that leadership as part of our thought that this is a place where there is bipartisan energy to do this, not just with

the Congress but also with Governors as well. So, I look forward to working with you on the areas you outlined. Those are the areas that we believe are the right strategic approach.

Senator PORTMAN. Well, and I do think HHS has a unique role to play in terms of best practices and research.

The final question is just on the budget. We have very little time left, but the obvious problem in our budget is health care. I remember when I left OMB, maybe when you left OMB, you had the same reaction. People said, what is the problem with the budget? Is it the tax system? Is it the wars overseas? Honestly, it is health care. Health care is driving these long-term projections that are simply unsustainable.

So I would say what I have told you before in your nomination hearings and so on: we are looking for help. I mean, Congress is hesitant to take on some of these issues because they are controversial, politically difficult. I look at your budget again and I think, you have taken health care costs over the next 10 years from increasing 105 percent, so more than a doubling, down to 99 percent, and you are taking credit for that.

When I look at the changes, frankly, a lot of them are not sustainable in my view, because they are cutting providers more in a way that has not been sustainable in the past. I think it would drive some providers away from providing Medicare coverage because of the way you do it.

So my only question is, when are we going to get serious about this? How do we get serious about it? If we do not, obviously we are not going to be able to deal with this historic level of debt we have. It has presented the economy, as you know, within the next 10 years, based on the Congressional Budget Office, with levels we have not seen since World War II.

Secretary BURWELL. With regard to the issue, I think we have put out proposals that we believe are a way of dealing with it in specific terms. Whether it is the proposal on Medicare Advantage and how we are implementing certain rules or some of the other things that your colleagues have raised on this side—some of our colleagues raised other concerns with our proposals. So we are proposing things that we believe, put together, create a balanced approach that does things on the provider side and does things on the other side.

Senator PORTMAN. My time has expired, and we have others who need to talk——

Secretary BURWELL. What we would like to do——

Senator PORTMAN [continuing]. But let me just make the obvious point, which is, we are still seeing under your budget a doubling of health care costs—and by the way, driven by a lot of things, but one is Obamacare—and significant increases in health care costs through that, about 62 percent of it, according to CBO. So these are issues that we are making worse, not better, by adding more entitlements that I hope we will get serious about addressing.

Secretary BURWELL. I do think it is important though to reflect that, in terms of Medicare cost growth on a per capita basis, it has been almost nearly flat in the past few years.

Senator PORTMAN. And why do you think that is? Sorry, Mr. Chairman. Just give me one second.

Secretary BURWELL. I think that there are a number of reasons. And this, though, gets to the point of the out-years. We as a Nation have a baby boom generation coming through. The number of people who are going to be on Medicare is going to be larger. As a Nation, we are going to have to make a decision about how we feel about that during the time in which that group of people has to pass through.

I think we are just going to have to make a decision about, what are we willing to do and how are we willing to think about that in terms of the choices that we make? Those choices come in the form of those people and the commitments that we have made, which I think both sides of the aisle believe that we should make good on, versus other changes.

Senator PORTMAN. Let me just—I know I am out of time. Let me just make the point here, again, that the Congressional Budget Office says—not Republicans, this is not me saying this—the main driver of that cost reduction in Medicare is Medicare Part D.

Where we allow competition, where we have transparency, where you have insurance companies competing for the business of our seniors, that is not the Obamacare model—which again, if you look at the analysis, Obamacare is responsible for 62 percent of the growth in Federal health care spending, and the age of the population, which you just talked about, the aging of the population is the reason for 21 percent. So we have to get serious about looking at what is actually working.

When Marilyn Tavenner, CMS Administrator, was before this committee, she said the actual costs on Part D are now 40 percent less than the original estimates, and this analysis by the agency responsible for the Federal budget shows that Part D is by far the main reason we have seen this reduction in Medicare spending. So my time has expired, but I look forward to continuing the conversation.

Secretary BURWELL. Thank you.

Senator THUNE [presiding]. Thank you, Senator Portman.

Senator Isakson?

Senator ISAKSON. Thank you, Senator Thune. And you were doing great, so I did not mind you taking the time. I would just put a little asterisk in there. Long-term entitlement reform is really one of the keys to getting the macro problem solved. I mean, the longer we wait in doing that, the worse it is going to be in terms of the debt in the out-years, and I appreciate your focus on that.

I want to take my 5 minutes to talk about the 10 minutes of your time I took last year. I had the benefit of being on the HELP Committee and the Finance Committee. Your confirmation came up, so I got two bites at the apple, and I used all 10 minutes to hold your feet to the fire on the Port of Savannah and getting it as a continuing project in the budget, until we finalized what had been a 16-year effort.

I want to publicly thank you for doing everything that you said you would do last year and acknowledge that, in this year's budget submitted by the President, it is a continuing project funded at $21 million for fiscal years 2015 and 2016. We thank you very much for that.

Secretary BURWELL. Thank you. Thank you, Senator.

Senator ISAKSON. Now, back to the subject at hand. As chairman of the Veterans Committee, I had a town hall meeting at the VA yesterday. There were four of us: the ranking members of the House and Senate and the chairs of the House and Senate. We spent 3 hours with over 400 employees of the VA, and we were on a nationally televised hook-up with every VA office in the country—340,000 employees in veterans' health care.

We found out yesterday morning, just as we were walking into that meeting, that the President's budget would portend that some of the Veterans Choice appropriations that were approved in the authorization last year might be moved if the utilization of Veterans Choice was not as great as it appeared it was going to be.

That really bothered me a lot, because we spent a lot of time last year debating the Veterans Choice Act, which would give veterans who live more than 40 miles from a VA facility, or veterans who could not get an appointment within 30 days, a chance to go to the private sector to a Medicare-approved physician and get the treatment that they needed. We have only had 1 month where that bill has been in effect, and that was the month of December, where we have the numbers.

In the month of December, of the 8.5 million veterans who received Veterans Choice cards, 150,000 actually inquired about an appointment. That is not enough evidence to tell you if it is going to be over-utilized or under-utilized, but I want to make sure the administration does not assume for some misguided reason that Veterans Choice is not going to be what it was expected to be when we passed it last year.

It is our one chance to see to it that we keep the promise to our veterans, we keep the veterans' health services from becoming such a huge organization that it is totally mismanaged, or totally undermanaged. And by the way, Secretary McDonald is doing a phenomenal job. He is applying business practices, he is serving without pay, he is doing everything you would ever ask a public servant to do. But if the administration is considering proposing cuts in Veterans Choice in the 2-year window that we appropriated last year, we are going to have some serious problems.

Secretary BURWELL. In terms of the VA budget and those VA issues, I would let Secretary McDonald speak to them. With regard to our interaction with VA, we continue to work on the areas and issues where we can. One of the most important places for us is in the mental health space, and we continue to work with VA.

The other place that is very important, and it does get to the care issue, is in the Office of the National Coordinator for Electronic Medical Records, because that is an important part of making sure that our veterans get the care they need, when they need it, where they need it, with the information they need. So those are the two places we interact, but I hear the point and will make sure that I share it with Secretary McDonald and others in the administration.

Senator ISAKSON. And we want to acknowledge to the President our appreciation that he signed the Clay Hunt Veterans Suicide Prevention bill yesterday. It is the single biggest problem facing us, and the VA is doing a good job of trying to get their arms around it. We have to stay the course and keep to the task.

Secretary BURWELL. Which is where we interact in terms of our substance abuse and mental health efforts in HHS, in terms of working on mental health issues and supporting the VA and our veterans in trying to work through those issues and make sure they have the care, the prevention, and the treatment that they need.

Senator ISAKSON. One last question, Mr. Chairman, if I can. In your proposal, you talk about adopting the bicameral agreement from last year and repealing and replacing the Sustainable Growth Rate. Is that correct?

Secretary BURWELL. What we have said is, we support this effort of moving forward. It is in our budget. We proposed both not letting the cuts occur as well as reforms in our budget. We are hopeful that this can be a bipartisan effort that will occur this year.

Senator ISAKSON. If I read the budget right, you assume the cost of repealing and replacing the SGR at $44 billion? The estimate out of CBO was $177 billion. What is the difference?

Secretary BURWELL. What the difference is, is there are two parts. When we assumed not doing the cuts, we built that into our baseline, so it is paid for in that way. There are also reforms that have been proposed, and the legislation that you are referring to actually has costs, and that is the number that you are seeing. That $44 billion is the number you are seeing in terms of the improvements, and some of those have costs, but in terms of the overall improvements, which is the bigger part, which is the cliff, that is in our baseline.

Senator ISAKSON. Well, thank you for your service and your time.

Secretary BURWELL. Thank you.

Senator THUNE. Thank you, Senator Isakson.

Secretary Burwell, a couple quick questions here. We have nine Indian tribes in my home State of South Dakota, so we have thousands of American Indians who depend on IHS in my State. My staff works regularly with the Office of Congressional Affairs, and previously officials from the Great Plains office, but unfortunately we are finding it difficult to get timely responses to our inquiries.

In fact, a recent example that comes to mind is the response I received last week from the IHS to a letter that we mailed 11 months ago. Additionally, my staff was recently prohibited from visiting an IHS facility without clearance, which took weeks to obtain from headquarters, which I believe is another example of just a lack of transparency and responsiveness.

I am wondering if you could speak to why the regional office has been instructed to not engage in even providing basic information to my staff or why my staff has been unable to visit IHS facilities without prior clearance from headquarters.

Secretary BURWELL. Senator, these are both examples that, I apologize, I do not know about. I will look into them and get back to you. I am hopeful—I think you know in the budget there are a number of proposals that we have with regard to IHS that are important, and I apologize that I do not know each of your tribes and whether they fall under direct support or not.

But there are a number of proposals for the tribes that do receive direct support that I think are extremely important to making sure we provide appropriate care, so I want to look into these issues. I

know your leadership on this issue, and I am hopeful that we can work together, because I think there are some very important things to do with regard to the quality of care and providing that care and not cannibalizing the care that we are providing. I will not go into that; I know you are familiar with the——

Senator THUNE. All right. Well, I appreciate that. I wanted to hear you commit to ensuring that the communication improves and that these inquiries get responded to in a more timely way.

Secretary BURWELL. I will follow up on both of those things.

Senator THUNE. The other thing I wanted to mention with regard to IHS is that, what we hear from providers who participate in the IHS Purchased/Referred Care program is that there is a frustration with the time and significant cost it takes to process claims.

So, as a result of that, last fall my staff convened a working group in South Dakota that included IHS, private providers, and tribal representatives to discuss ways that we could improve that claims administration process. As a result of that meeting, we have a commitment from the stakeholders to continue to discuss this issue in follow-up meetings.

But one particular area of improvement that was suggested was to use electronic mechanisms to exchange information in the processes, in the claims and payment processes. So in the PRC program, claims are still being mailed in paper form back and forth. It seems that the focus to move providers and payers to electronic health records should include the IHS and their relationship with private providers.

So is that something that you agree with? I mean, using a paper claims process seems to be very antiquated, inefficient, and ought to be changed. So would you commit to working with us and with other stakeholders on a way that we can achieve some program efficiencies that might include and incorporate electronic records?

Secretary BURWELL. Yes, and we would like to hear what you are hearing. When I met with the Secretary's Tribal Advisory Committee about these issues, one of the things that they are raising is, as we push to have electronic medical records in the tribes, the question of their ability to do that and on what time table.

We would welcome the conversation, because I think it will help with the issue you are talking about in terms of our claims processing. They have expressed some concerns, but this is a place where, let us see what we can do to move the ball forward, including ways to think about assisting and helping them with moving towards the electronic medical records, because it will help with the other issues.

Senator THUNE. All right.

Secretary BURWELL. And the other thing is, though, this does also get to predictability and funding.

Senator THUNE. Right.

Secretary BURWELL. Which gets to some of the other issues in the budget in terms of those payments of claims.

Senator THUNE. Right. A final point. The world of tele-health, digital medicine, has grown by leaps and bounds in the last few years, but it seems like the regulatory regime that sort of governs that, particularly related to payment and use of tele-health, has not kept pace. So the question is, what can HHS do to evaluate the

current regulatory environment and make changes to catch up and keep up?

We have seen a lot of pioneering work done in my State with the use of tele-medicine, but it is very, very hard to deal with all the payment issues and some of the bureaucratic regulatory issues that seem very outdated relative to the technology that I think would be incredibly effective in meeting health care needs, particularly in rural areas.

Secretary BURWELL. So, one, I continue to work on these issues and have made some progress, but I think you are right in terms of, there is this place where we can continue to make progress.

I think one of the ways to do that is to make this a part of the conversation on delivery system reform, because it is a way that we can provide greater quality care and a more efficient way of doing it. So, I think we need to make it a part of that.

I think the other thing is how we have the conversation with those who are not as supportive of changes in this space in terms of using tele-health as care. So those are the two things. I think having it sit within delivery system reform is important, and then the second thing is how we can work together with those who oppose greater speed with regard to moving it forward.

Senator THUNE. Yes. All right. My time is up. Thank you, Madam Secretary.

Senator Carper?

Secretary BURWELL. Thank you.

Senator CARPER. Thank you, Mr. Chairman.

Madam Secretary, great to see you. Thanks for your leadership and your service in so many different roles for our country. I am concerned. I am sorry I could not be here earlier; we got bounced back and forth between three different hearings, all of which are really terrific and important hearings.

I am concerned about the funding cliff that is faced by our federally qualified community health centers. We know it is a steep cliff. I understand from the President's budget that he calls for addressing the funding cliff with a multi-year solution to provide stable and maybe more predictable funding to these essential health centers.

Could you just talk about the effects of our failing to address this funding cliff? I want to ask if we can count on the administration's commitment, your commitment, to working with us to make sure that health care centers receive sufficient funding to continue their investments in care and service to meet the needs of our communities.

Secretary BURWELL. With regard to our budget, we actually both address the funding cliff but also address that we believe that there are greater needs. Our budget actually funds 75 new health centers, and those are generally for under-served communities, often rural but not always, around the country. So our commitment is to address the funding cliff which we think would have a very detrimental effect on those health centers.

I have traveled around the country, seen the folks who are being served by those centers, and it is a very important part of serving communities around the country, in terms of millions who are re-

ceiving their care at these centers, and so a cliff would mean a dramatic change for them.

Senator CARPER. Thank you. Thanks very much.

From my earlier conversations, past conversations, you know I am a big supporter of your ongoing efforts to move our country's health care system away from volume-based toward value-based payment for care. Your announcement last week to push forward with the ambitious goal of moving, I think, nearly all Medicare payments into these value-based arrangements by, I think, 2018 helps, I think, solidify this promising future.

Delaware, as you know, is right beside you, and we are grateful that our State has received a State innovation model grant so that we can design and test payment and service delivery models. Providers in my little State are, even at this moment, rightly concerned about the financial implications of a transition to value-based payment models, but they are actively working together with State officials and across payers to figure out how to make this shift.

Here is my question. Would you please discuss with us some of the improvements in health care outcomes as well as cost savings that may have already been realized in the last few years due to value-based Medicare reimbursements and the demonstration of new payment arrangements in various States?

Secretary BURWELL. With regard to value-based payments, we are starting to move forward, and we see that there are providers who are receiving the benefits and rewards of those, and there are also those providers who are in the bottom part of what they are doing who are receiving the payment cuts, and so we are starting to see that.

With regard to some of the models that we are using, the alternative payment models, one of the things that we are seeing is how Accountable Care Organizations are working, and we are already seeing the actual financial savings in that, up into the hundreds of millions of dollars, in terms of what we think we can do there.

One of the things we want to do is continue—and this is something that our budget talks about—making sure that we have the flexibility so that, as we go, we learn and we incorporate the things that they believe will be the right incentives.

We discussed this with Senator Cantwell when she was here, in terms of making sure we have the right incentives to keep people moving on that path and addressing the various kinds of issues. As you said, they are moving, but there are concerns that get raised.

Senator CARPER. All right. Thank you.

Another issue that Tom Coburn and I, a former colleague from Oklahoma, have talked with you and your predecessors about ad nauseam is the improper payments. It has been on the high-risk list for the GAO, the Government Accountability Office, forever, and it remains there.

A number of years ago we—Dr. Coburn and I, in the Bush administration and then in the Obama administration—focused, focused, focused on this with GAO and started to see that number being driven down, which is good. It is over $100 billion a year, as you know, government-wide.

This last round, we have seen some reduction in improper payments in a variety of parts of our government, but not in Medicare. In fact, we saw a bump-up in Medicare, and it concerns me. If you could, just talk about that. Should we be concerned? Are you concerned? What can you do, your Department do, what can we do to help reverse that and get it headed back down?

Secretary BURWELL. There are a number of things that we can do, I think, to do that. Within Medicare, in terms of A, B, C, and D, the different parts of Medicare, we see actually some of it continuing on the right path and some of it not, so there are places within Medicare that we think are directionally correct in terms of that continuing downward trend on the issue of doing better on our program integrity.

I think in our budget, we propose funding that we think is important to continuing these efforts. I think we also need to work through efforts—and we have talked a little bit here today about some of the rules and some of the regulations here that are statutorily on hold for reasons that people have raised issues with.

But I think what we need to do is work through those concerns so that we can continue on the path, in terms of making sure we are recovering those improper payments. We have seen, I think as you know, some record returns in terms of the issues specifically around fraud, an 8 to 1 return and a record year in 2013 in terms of what we are getting in. We want to continue working on that, and we do not want to be in a pay-and-chase mode, but a more preventative mode. So those are some of the things we are doing. The budget focuses on this specifically in terms of some of the funding that we have asked for.

Senator CARPER. Good. Well, I think we agree it is important to continue our efforts, and we want to be helpful. Let us know how we can do that. Thank you.

Secretary BURWELL. Thank you.

Senator CARPER. And again, thanks for your service.

Secretary BURWELL. Thank you.

Senator ISAKSON [presiding]. Secretary Burwell, I think Senator Wyden has an additional question, if you do not mind.

Senator WYDEN. Thank you, Senator Isakson. Two questions, just very briefly. It has been a long morning, and you have been very patient.

Madam Secretary, Senator Isakson and I, and colleagues on both sides, have taken a special interest in Alzheimer's. As you know, Alzheimer's is just hitting millions of American families like a wrecking ball. What we see is families just really being in agony because they cannot even pay for the kind of care that they want their loved one to have.

My question is, I think it is understood that the fight against Alzheimer's now has scores of private entities, companies, researchers, and others, and there are some public institutions obviously involved as well. Your Department holds a couple of pieces of the puzzle. The research area is one. Certainly we have been talking about chronic disease and how we are going to come up with a coordinated system of caring for those with chronic disease, of which Alzheimer's is right up at the top.

But there is one question that I get asked all the time, and it really is what I wanted to touch on today, and maybe we are just going to begin to have this discussion. But whose job, in your view, is it to try to put together a game plan to beat Alzheimer's? We have this array of private and public parties, people who are working very hard and mean well. Is there any discussion that you know of that even focuses on who might be, or the group of people who would be tasked with coming up with a plan to beat this horrible scourge that is taking such a toll on our families?

Secretary BURWELL. With regard to the question of beating it, I think you know that in this budget we have almost $3.2 billion committed to these issues, and, as you said, we are a payer. The largest portion of that is in what we pay in Medicare in terms of paying for the care that you mentioned. We are the researcher, in terms of how we add to the research, and we have increases in that that you see in NIH.

I think the question of beating it—we actually need to make progress on the research and understanding the science so that we can work toward that. We need to make sure that we are helping families afford the care that they are seeking.

Then the third element actually is about how people actually go through this process and whether you are the individual who is suffering or the caregiver. That falls under the Administration for Community Living. So this question of beating it, I think, has three fundamental elements to it: research, pay for care, as well as how you handle it.

One of the things that I think is important is that the Administration for Community Living—and I should mention there are also other elements of HHS that have small bits, but those are the main ones. I think one of the places where we can focus this year is in the White House Conference on Aging and using that as an opportunity to bring together some of these pieces. Within our budget, what you see is the energy that is leading up to the increase in NIH and the increase in the ACL.

Senator WYDEN. Let us do this. I know this question caught you cold. You and I talk about a lot of stuff. I have not asked that particular question before. I want to continue this. Maybe the White House Conference on Aging is the place to do it, but it just seems to me that this is something that has to be put that way. How do you put in place a game plan to beat it?

One last question if I might, Mr. Chairman, very quickly, and it deals with something else that this committee is tasked with and is very important, and that is foster care. Now, as you know, Madam Secretary, the big foster care program, I guess it is called title IV–E, does not kick in until a child is removed from their home. And I think you all are talking now about some approaches to really come up with preventive services for kids who are candidates for foster care but are not quite there.

Senator Isakson has been incredibly patient. Why don't you give me a brief answer, if you could, in terms of how this might work for an individual kid? In other words, you have a real kid, and you want to get that child, he or she, preventive services. How do you do it?

Secretary BURWELL. So right now, the question of getting that child preventative services, what would happen at the point at which the child is near removal, they would just end up being removed. And what we can do is get in and provide the support to the States and communities in providing services so their parents, their existing family before they are removed, could get some support.

Maybe that is respite care because the child has certain issues, maybe that is other services that the child needs. But what happens is, in the system now, too often the answer is, just move the child versus, can we understand the underlying causes?

So what we want to do is create the flexibility that funding can be used to try to address causes and things that could help keep the child safely in the existing setting. We believe that can be better for the child. We want to do it always in a safe way, but we believe we need some flexibility to be able to do that in terms of how our funding can currently be used.

Senator WYDEN. Senator Isakson, you are going to wrap up.

Senator ISAKSON. Thank you, Senator Wyden. Thank you very much, Secretary Burwell, for your appearance today. I want to thank all the Senators who appeared and questioned today. It has been a good hearing, I think, and a long one. Thanks for your patience.

Any questions for the record should be submitted no later than Wednesday, February 11th.

This hearing stands adjourned.

[Whereupon, at 12:35 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

LETTERS SUBMITTED BY HON. SHERROD BROWN,
A U.S. SENATOR FROM OHIO

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STATE OF ALABAMA

November 6, 2014

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
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The Honorable Ron Wyden
Chairman
Committee on Finance
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Washington, DC 20510

The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
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Washington, DC 20515

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Upton, Chairman Wyden, Ranking Member Waxman and Ranking Member Hatch:

Thank you for seeking governors' input on the Children's Health Insurance Program (CHIP). This important state-federal partnership provides access to vital health care services for many Alabama children, and I encourage Congress to act soon to extend CHIP for four years.

CHIP in Alabama

As of June 2014, Alabama had 86,218 people enrolled in CHIP: 57,872 were emailed in ALL Kids (Alabama's separate CHIP) and 28,346 were enrolled in the Medicaid portion of CHIP. Among Alabama's CHIP enrollees, 58 percent are 12 or younger and 42 percent are 13 to 18 years of age. Also, 49 percent are white, 25 percent are black and 26 percent are Hispanic or have other racial or ethnic backgrounds. In addition, 33 percent of our enrollees are in families with incomes of 100 to 141 percent of the federal poverty level, 43 percent are in families with incomes of 142 to 200 percent of the poverty level and 24 percent are in families with incomes of 201 to 312 percent of the poverty level.

Changes to CHIP as a Result of the Patient Protection and Affordable Care Act (PPACA)

Alabama's CHIP, at the federal government's direction, moved about 23,000 children to Medicaid on January 1, 2014. Medicaid provides the children with health care, but the care is funded by CHIP. Also, Alabama has built a new eligibility system

to meet requirements of PPACA. The system has a rules-based engine for determining eligibility for both Medicaid and CHIP based on modified adjusted gross incomes. The system also interacts with the federally facilitated Market place, the Internal Revenue Service and the Federal Data Hub. In addition, Alabama's CHIP erased a three-month waiting period to comply with PPACA.

Unique Benefits in Alabama's CHIP

Alabama's CHIP provides nutritional counseling and extra primary care office visits for obese children. Also, Alabama's CHIP generally has lower copays than other insurance plans.

CHIP Extension

Congress should extend CHIP funding for four years to provide health care for many of our children. I ask that Congress act soon. We have started budgeting for the 2016 fiscal year, and CHIP's funding uncertainty complicates that task. The uncertainty of CHIP funding is also stressful for parents trying to make sure their children have health insurance.

Alabama does not have precise estimates of the number of children who would be uninsured without CHIP, but the number likely would be large. Many CHIP enrollees could have access to health insurance through a parent's employer, but the coverage almost certainly would cost more and might be unaffordable. Also, family coverage for policies bought on the Marketplace likely would be out of reach for many CHIP families. People cannot qualify for tax credits to lower the cost of Marketplace policies if single coverage available through an employer would cost 9.5 percent or less of household income. The tax credits are unavailable even if family coverage through an employer would cost 20 percent or more of household income. Without CHIP, many of our children will be uninsured.

Unspent Allotments

Unspent federal allotments have not been a problem for Alabama. The funding formula, however, may need to be adjusted to ensure that Alabama and other states have adequate allotments to cover CHIP spending. Without carryover funds from 2010, funding provided to Alabama in the 2011 fiscal year would not have covered costs.

Uninsured Rate

Before CHIP, the uninsured rate for children in Alabama was 15 percent. In 2013, the uninsured rate for children in Alabama was 8.2 percent. That rate could fall even further if the Federal Medical Assistance Percentage for CHIP is raised by 23 percentage points as called for by PPACA starting in the 2016 fiscal year.

CHIP is successful. It was started to give kids access to health insurance. There is still a need for it. Through CHIP, Congress has provided routine care and life-saving care for our children. I ask you to extend CHIP funding for four years, and to do it soon. Thank you for giving me the chance to comment on this vital program. Please contact my office if we may assist you further.

Robert Bentley
Governor

The State of ALASKA

GOVERNOR SEAN PARNELL

Department of Health and Social Services

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October 23, 2014

The Honorable Fred Upton
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The Honorable Orrin Hatch
Ranking Member
Committee on Finance
United States Senate
104 Hart Senate Office Building
Washington, DC 20510

Dear Congressmen Upton and Waxman and Senators Wyden and Hatch,

In response to your letter to Governor Sean Parnell, dated July 29, 2014, regarding Children's Health Insurance Program (CHIP) funding and additional information that would be helpful as you work through the funding extension process, please find the following response to your questions:

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?
   - We had 10,725 children enrolled on the last day of the quarter ending September 30, 2013.
   - Our eligibility standards for the program are:
     – Ages 0–5: 160–203 percent of the federal poverty level
     – Ages 6–18: 125–203 percent of the federal poverty level
   - At the State level, the Medicaid agency has demonstrated improvement in children's quality of care as shown through the 15 children's quality measures.
2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?
   - There have been no substantive changes, with the exception of those due to modified adjusted gross income (MAGI) and the conversion to Survey of Income and Program Participation (SIPP) plus one percent standards required under the PPACA.
   - The MAGI SIPP conversion requirements are a direct impact of PPACA, as the law requires us to include income disregarded under prior law.
3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

- The early periodic screening diagnosis and treatment (EPSDT) comprehensive child coverage is available to all children enrolled in Medicaid in Alaska. Therefore, the coverage available to the CHIP population is much more comprehensive that the coverage which is available in the Health Insurance Marketplace. Additionally, there is no cost sharing in Alaska's CHIP program. Some services that CHIP provides that private insurance may not are:
  - Inpatient and outpatient behavioral health services
  - Vision exams and corrective lenses
  - Hearing exams and hearing aids
  - Physical and occupational therapy
  - Services for speech, hearing and language disorders
  - Durable Medical Equipment

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?
   - The State of Alaska recommends that CHIP funding be extended at least through September 30, 2019 to match the maintenance of eligibility requirements (MOE) under the PPACA.
   - Alaska is an M–CHIP state. We do not have a free-standing CHIP program, so the 10,725 enrolled children will have coverage through September 30, 2019.
5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?
   - Yes, the CHIPRA federal funding allotment formulas and methodologies have worked well for Alaska.
   - States have two years to spend their allotments so the Fiscal Year 2015 allotment could go out through September 30, 2016. If Congress does not extend CHIP funding, the unspent allotments should be addressed.
6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component to that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?
   - Yes, the federal government could assist in enrolling eligible children by continuing to support the express lane eligibility provision between child health and social/human service programs, and by working to standardize the basic eligibility requirements across all programs.
   - The quality improvement work under the CHIPRA children's quality demonstration grants has been very helpful to Alaska Medicaid/CHIP programs. We would recommend the continuation of the children's quality improvement work.

The State of Alaska supports the CHIP program, as it gives much needed coverage to approximately three million children nationwide. As state earlier, the CHIP program in Alaska allows children to receive coverage for services that private health insurance and the Exchange may not cover.

If you need any additional information please feel free to contact me.

Sincerely, William J. Streur
Commissioner
Alaska Department of Health and Social Services

STATE OF ARIZONA

JANICE K. BREWER
Governor

EXECUTIVE OFFICE

November 13, 2014

The Honorable Fred Upton
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The Honorable Ron Wyden
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The Honorable Henry Waxman
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The Honorable Orrin Hatch
Ranking Member
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219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Upton:

This letter serves as Arizona's reply to your correspondence dated July 29, 2014 regarding the Children's Health Insurance Program (CHIP). KidsCare is Arizona's CHIP program.

1. How many individuals are served by your state's CHIP program'? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

   AZ Reply: KidsCare serves children in households between 133% of the federal poverty level (FPL) to 200% FPL. Parents have a monthly premium requirement that is assessed on a sliding seal based on income. In general, KidsCare members are healthier than the average Medicaid enrollee, with a per-member per-month cost of $206.

   As part of the Arizona's effort to address the fiscal challenges associated with the Great Recession, the State froze enrollment to KidsCare in January 2010. To mitigate the impact of that enrollment freeze, Arizona had 1115 demonstration authority that allowed temporary KidsCare enrollment funded by political subdivisions. Under that demonstration, KidsCare enrollment reached 46,761 by the end of 2013 before federal authority expired. Subsequently, most enrolled children were transitioned to Medicaid, white 14,000 were transitioned to the Federally Facilitated Marketplace (Marketplace). Arizona does not have data on the Marketplace take up rate of those 14,000. The State agreed to provide data on the 14,000 to MACPAC (Medicaid and CHIP Payment and Access Commission) to match with Marketplace enrollment data, but the Marketplace declined MACPAC's request. Currently, there are 1,945 children enrolled in KidsCare.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act (PPACA)? How has the implementation of PPACA impacted the way your state administers CHIP?

   AZ Reply: Arizona has not made any changes to its KidsCare program as a result of PPACA.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and/or benefits and/or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

   AZ Reply: Arizona provides the full Medicaid benefit package to KidsCare members. The State selected its state employee benefit package as the benchmark for Marketplace coverage. Those benefits align fairly closely to the Medicaid benefits package. The Primary difference for children is non-emergency medical transportation, which is not offered in the Marketplace. There also are

some family supports and other behavioral health services that may not be offered on the Marketplace.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

   AZ Reply: Arizona led the nation in the percentage of children who enrolled in health care through the Marketplace with 21% of enrollees under age 18 (compared to the national average of 6%). KidsCare has been a incredible success in Arizona and served many families well. While there may be some differences between the Marketplace and KidsCare, especially related to out-of-pocket expenses and cost sharing, there is no reason to believe that a Marketplace option cannot be structured to meet the needs of children in this income range.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

   AZ Reply: Although Arizona's example presents some unique issues, it exemplifies the dynamic nature of health care. A five or six year formula struggles to address shifting state needs. In one instance, Arizona had an unspent allotment and just a couple of years later, Arizona required an increase. Ideally, the formula allows for greater flexibility to keep pace with state needs.

6. Over the past number of years, States have worked to reduce the number of uninsured children. And Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?

   AZ Reply: Arizona has had tremendous success in enrolling eligible individuals through its public/private partnership that allows community organizations, providers, faith-based groups and others to be part of the application assistance team. These groups are trained by the State for use of the actual eligibility online system, know as Health-e-Arizona Plus. Over 100 organizations have agreements with the State as application assisters. Through those organizations, the State has trained over 2,000 non-State employees to provide application assistance in the community representing organizations all across the State. Moving away from a government-run model to one that is partnership focused has been a success.

Sincerely,

Janice K. Brewer
Governor

CC: Senator John McCain
Senator Jeff Flake
Representative Ann Kirkpatrick
Representative Ron Barber
Representative Raúl Grijalva
Representative Paul Gosar
Representative Matt Salmon
Representative David Schweikert
Representative Ed Pastor
Representative Trent Franks
Representative Kyrsten Sinema

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October 20, 2014

Fred Upton, Chairman
House Committee on Energy and Commerce

Henry A. Waxman, Ranking Member
House Committee on Energy and Commerce

Ron Wyden, Chairman
Senate Finance Committee

Orrin G. Hatch, Ranking Member
Senate Finance Committee

Congress of the United States
Washington, DC 20515

Dear Chairmen Upton and Wyden; Members Waxman and Hatch:

In response to your July 29, 2014 request for information from governors regarding the Children's Health Insurance Program (CHIP), I welcome this opportunity to provide information on Arkansas's successful CHIP program (ARKids-B and Unborn Child programs) and my thoughts regarding the future of the CHIP program.

The ARKids First program began in Arkansas in 1997. At that time, 22% of children in Arkansas lacked health coverage. ARKids First is made up of two programs. ARKids-A is traditional Medicaid for children and offers low-income families a comprehensive package of benefits. ARKids-B is funded by Title XXI (CHIP) and offers a similar benefit for families with higher incomes. The ARKids First program has played an important role in significantly dropping the percentage of children without access to coverage. Currently, 80,400 children in Arkansas are provided health coverage through the ARKids-B and Unborn Child programs of which the majority of children covered are in the ARKids-B program.

The passage of the Patient Protection and Affordable Care Act (PPACA) has led to changes in the administration of the ARKids-B program. Specifically, Arkansas converted the state's existing income eligibility standards as required by the PPACA to a Modified Adjusted Gross Income (MAGI) equivalent standard. Additionally, as required by PPACA, Arkansas has transferred children ages six through eighteen with incomes above 100% of the federal poverty level (FPL) up to and including 133% FPL from the ARKids-B program into the ARKids-A program.

ARKids-B provides coverage for vision and dental services. These benefits have historically not been covered through the majority of employer sponsored health plans. In the Arkansas Health Insurance Marketplace, pediatric dental services are not required to be offered as a part of the package of benefits along with the other essential health benefits, if a stand-alone pediatric dental plan is offered on the Marketplace.

As previously mentioned, the CHIP program has worked well in Arkansas. The annual allotments have been adequate and the funding formula is working appropriately. Thus, we do not believe there is a need for Congress to address the issue of unspent allotments. Continuing to provide coverage for children in Arkansas is imperative. Thus far, our experience with the CHIP program in Arkansas has been overwhelmingly positive and successful and has led to a dramatic reduction in the percentage of uninsured children. Whether coverage remains to be provided through continued funding of CHIP or via an alternate mechanism (e.g. providing coverage through the Marketplace), ensuring that our state's children do not lose access to coverage is critical.

Thank you for the opportunity to comment on Arkansas's experience with the CHIP program and to provide input on this important policy debate.

Sincerely,

Dawn Stehle
Medicaid Director

State of California
HEALTH AND HUMAN SERVICES AGENCY

Aging • Child Support Services • Community Services and Development • Developmental Services
Emergency Medical Services Authority • Health Care Services • Managed Health Care • Public Health
Rehabilitation • Social Services • State Hospitals • Statewide Health Planning and Development

EDMUND G. BROWN JR.
GOVERNOR

DIANA S. DOOLEY
SECRETARY

October 30, 2014

The Honorable Fred Upton, Chairman
House Committee on Energy and Commerce
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The Honorable Ron Wyden, Chairman
Senate Finance Committee
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The Honorable Orrin G. Hatch, Ranking Member
Senate Finance Committee
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The Honorable Henry A. Waxman, Ranking Member
House Committee on Energy and Commerce
2204 Rayburn House Office Building
Washington, DC 20515

Dear Members of the United States Congress:

I strongly encourage Congress to act early and extend the Children's Health Insurance Program (CHIP) funding to the states beyond federal fiscal year 2015. Since California's enactment of this program in 1997, we have valued and relied upon federal CHIP funding to provide comprehensive, affordable health care, mental health, and substance use treatment coverage for children and pregnant women to ensure the best possible health care outcomes for children and infants.

By providing coverage for low to moderate income children and pregnant women through CHIP, cost-sharing is significantly lower than through other subsidized coverage, such as through California's state-based health benefit exchange, or private health plans. This ensures that cost-sharing requirements for these children and pregnant women is not an access barrier to care. Together, CHIP and Medi-Cal, California's Medicaid program, have cut the rate of uninsured children in California by half—from 10.3 percent in 2001 to 5.1 percent in 2011, according to the California Health Interview Survey by the University of California, Los Angeles, Center for Health Policy Research.

If federal CHIP funds are not renewed for Federal Fiscal Year 2015, California could lose upwards of $533 million annually. Renewal of federal CHIP funding is extraordinarily important to California's fiscal stability and the ability to continue to offer cost-effective, affordable coverage for children and pregnant women. California makes every effort to maximize its federal CHIP allotments and fully expects to do the same with the enhanced federal matching rate as part of CHIP renewal. The enhanced federal CHIP funding supports a 23-percentage point increase (also known as the "CHIP bump") in the federal match rate for California. This is an important investment in children's health care. The loss of such funding would put gains in children and infants' health coverage at risk.

California recommends early approval of the extension of this funding to ensure no lapse in the California State Fiscal Year (FY) 2015/16 budgeting process for these important programs. CHIP renewal would encourage health coverage enrollment and positive health outcomes for children by generating permanent efficiencies in enrollment and renewal simplification processes, as well as improvements in the quality of pediatric health care delivery.

Enclosed with this letter are California's responses to questions outlined in your letter dated July 29, 2014. If you have additional questions or would like to discuss the responses further, please contact Mr. Toby Douglas, Director, California Department of Health Care Services.

Sincerely,

Diana S. Dooley
Secretary

Enclosure

ATTACHMENT

California is pleased to provide the following information to the Congressional committees with Jurisdiction over the Children's Health Insurance Program (CHIP) regarding the extension of funding for CHIP beyond Federal Fiscal Year (FY) 2015.

California Background:

California has a robust CHIP program that is administered by the Department of Health Care Services (DHCS), the single state Medicaid agency (known as Medi-Cal in California). Prior to January 1, 2013, the Managed Risk Medical Insurance Board (MRMIB), a state board separate from DHCS, administered the largest component of California's CHIP, previously known as the Healthy Families Program (HFP). HFP was transitioned to DHCS throughout Calendar Year 2013. Under this transition, children previously eligible for HFP, under a standalone CHIP, became Medi-Cal eligible under a new Medicaid expansion coverage group, known as the Optional Targeted Low Income Children's Program (OTLICP). The other transitioned CHIP programs now administered by OHCS are as follows:

- The Medi-Cal Access Program, (previously known as the Access for Infants and Mothers Program [AIM]) which provides comprehensive medically necessary services to pregnant women who are above the Medi-Cal income standard, up to and including 322 percent of the federal poverty level (FPL). Additionally, those infants born to women enrolled in the Medi-Cal Access Program with incomes above 266 percent (the OTLICP upper income limit) and up to and including 322 percent are also covered under this program for up to their first two years of life.
- The County Children's Health Initiative Matching (C–CHIP) Program, historically funded solely by local county and federal funds in three counties (San Francisco, San Mateo, and Santa Clara) that voluntarily chose to operate a C–CHIP program, offers comprehensive coverage to CHIP-eligible children who are above the applicable Medi-Cal/CHIP limits up to and including 322 percent. Today, as a result of the ACA maintenance of effort eligibility requirements, state and local county funds are used as the non-federal share to draw down unused federal State CHIP/Social Security Act Title XXI funds for CHIP-eligible children in these three counties.

How many individuals does your state's CHIP serve?

As of August 30, 2014, there are approximately 1,257,500 low-income children and pregnant women enrolled under California's CHIP programs in which Title XXI funds are used to support medically necessary health, mental health, and substance use disorder services. The CHIP funded programs are:

- Medicaid Expansion for Low-Income Children and Pregnant Women
- Optional Targeted Low Income Children's Program
- Medi-Cal Access Program for Pregnant Women and Infants
- County Children's Health Initiative Matching Program

What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

The following charts provide a summary of demographic characteristics of CHIP enrollees in California.

Chart 1: Medicaid Expansion Population

Children under the age of 19	Pregnant Women (Unborn Option)
• FPL income level: – Children 1–6 up to and including 142 percent – Children 6–19 up to and including 133 percent • Full scope Medi-Cal coverage	• FPL income level above 60 percent up to and including 208 percent • Pregnancy-related covered services

Chart 2A: CHIP Population

OTLICP (Children under age 19 above traditional Medicaid income levels)	Medi-Cal Access Program (Pregnant Women)	Medi-Cal Access Infant-Linked Program (Children under 2, born to mothers enrolled in Medi-Cal Access Program)
FPL Income level • Infants 0–1 above 208 percent up to and including 266 percent • 1–6 above 142 percent up to and including 266 percent • 6–19 above 133 percent up to and including 266 percent	FPL Income level • Above 208 percent and up to and including 322 percent	FPL Income level • Income above 266 percent up to and including 322 percent
• Subject to premiums when FPL >150 percent not to exceed the 5 percent limit on their monthly income – $13 per child up to a maximum of $39 per month for households with three or more children – No copayments on covered services • Native American/Alaskan Indian Exemption	• No maternity insurance or have health insurance with a high (over $500) maternity-only deductible • Total cost for enrollment = 1.5 percent of family's adjusted annual household income after applying standard deduction	• Enrolled in share-of-cost Medi-Cal • Subject to premiums based on income and household size – $13 per child up to a maximum of $39 per month for households with three or more children • Native American/Alaskan Indian Exemption

Chart 2B: CHIP Population County Operated

Santa Clara, San Francisco and San Mateo.	Children under age 19 FPL Income level • Above 266 percent and up to and including 322 percent • Uninsured, or enrolled in share-of-cost Medi-Cal or Medi-Cal Access Infants Program • Subject to premiums based on income and household size
Santa Clara	• $4 to $21 per child monthly premium with maximum cost of $63 per family per month • No copayments for preventative services • $5 to $15 copayments for other medical, dental and vision services • Maximum of $250 in copayments per family in a Benefit Year, does not include copayments for dental and vision services
San Francisco	• $48 to $189 annual premium based on household income and family size • $5 and $10 copayments for most services
San Mateo	• $0 to $90 quarterly premium based on family income • No copayment for check-ups, immunizations, annual dental exams, and other preventative services • $5 to $15 copayments for most services

What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act (PPACA)?

To ensure achievement of the overall purpose of the PPACA, California began with the enactment of Assembly Bill 1296 (Bonilla, Chapter 641, Statutes of 2011), which among other things required the development of a standardized single, accessible application form and renewal procedures for state insurance affordability programs.

Additionally, California transitioned the State's separate CHIP programs for children and pregnant women and their infants to DHCS administration, beginning in 2013. This has effectively resulted in the integration of the standalone CHIP and the Medicaid expansion under the Medi-Cal program. The goals in the transition of children and pregnant women to Medi-Cal under DHCS are to provide a uniform approach for potential beneficiaries applying for and obtaining health care coverage

under applicable insurance affordability programs, to streamline eligibility and enrollment processes, and to broadly simplify coverage options for individuals under Medi-Cal and California's state-based health benefit exchange.

How has the implementation of the PPACA impacted the way your state administers CHIP?

As indicated above, the implementation of PPACA set in motion the creation of a Medicaid expansion for children by moving from a standalone CHIP to the movement of CHIP-eligible children under the Medi-Cal program. This integration has allowed California the ability to apply Medicaid cost sharing principles to CHIP-eligible children and to make available to these children the expanded benefit package of Medi-Cal as described in the response on covered benefits. California also expanded coverage to children between the ages of 6 to 19 years of age with family income up to 133 percent.

Specifically, PPACA has influenced the way in which California administers CHIP-funded programs in the following ways:

- Implemented the use of streamlined eligibility processes and coverage options for children and adults seeking coverage under insurance affordability programs, including CHIP, using a federally-approved, single streamlined application.
- Established a "no wrong door" approach for enrollment. Individuals are first assessed for no-cost coverage under Medi-Cal/CHIP using one intake process before moving to programs that require cost-sharing or advanced premium tax credits. This approach allows consumers to obtain health insurance at the lowest cost with a streamlined application and provides the option for families with children to shop, compare, and select coverage under one health plan if available in their county of residence.
- Provided additional benefits and lowered costs for children at certain income levels.
- Gained overall administrative efficiencies and oversight, including more consistency in health plan contracting processes while increasing plan accountability for providing high-quality services to children.
- Provides the opportunity to standardize the existing administrative appeals process for consumers for initial eligibility or enrollment determinations and redeterminations for insurance affordability programs both Medicaid and CHIP funded, with procedures and timelines for hearings with the appeals entity with continuing eligibility for beneficiaries during the appeals process.
- Achieved operational efficiencies by consolidating administrative resources under one state agency

To the extent the following information is readily available and you believe It is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Benefits

All children enrolled in the Medi-Cal program funded with Title XXI and Title XIX receive the same Medi-Cal benefits and use the same health care delivery systems. Through Medi-Cal, CHIP-eligible children have access to a more comprehensive coverage package at a lower cost to families than that which is available through private or state exchange coverage. Given the incorporation of CHIP-eligible children as a coverage group under the state plan, the funded services includes the comprehensive Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit which also has a more liberal standard for medical necessity and has been considered the gold standard for publically financed programs. Additionally, these children also receive dental and vision benefits, mental health, and substance use disorder services. Comparatively, children enrolled through Covered California or employer-sponsored health plans receive the required ten essential health benefits but have higher out-of-pocket expenditures.

Pregnant women in the Medi-Cal Access Program receive the minimum essential health benefits from their health plan, which also includes the following services:

- Physician and Professional Services

- Mental health and substance use disorder services including behavioral health treatment
- Preventative and wellness services; and chronic disease management
- Maternity services
- Hospital care
- Prescription drugs
- Non-emergency medical transportation services
- Skilled Nursing Facility Services (91+ days) offered to pregnant women until the end of the woman's postpartum period if medically necessary
- Pediatric services for income-eligible children including oral and vision care

Cost-Sharing

Previously, families whose children enrolled in HFP paid a monthly premium amount based on income and family size with the state's program administrative vendor tracking the payments and cost sharing requirements. Families' premiums fluctuated based on a change in income level, much like Covered California coverage that is based on family size. Cost-sharing for the OTLICP under Medi-Cal is based upon a flat monthly rate established in state law. The state monitors the process for payment of premiums and cost-sharing. As a result of the change to premiums for children under Medi-Cal, families receive either a lower monthly premium or none at all. Medi-Cal does not require co-payments for children under the age of 19. These policies ensure that premiums, co-payments, and deductibles are not a barrier for children and pregnant women to access care. Retaining CHIP funding is critical for achieving affordable, comprehensive coverage for low-income children and their families.

The total cost-sharing for women enrolled in the Medi-Cal Access Program is 1.5 percent of the family's adjusted annual household income after applying the standard deduction. The cost sharing amount for pregnancy and post-partum can be divided into 12 monthly installments, but enrollees may choose to pay the entire 1.5 percent cost in one single payment including a $50 discount.

Covered California, which is California's state-based health benefit exchange, offers health plans with four major metal tiers: Bronze, Silver, Gold, and Platinum. Each health plan provides minimum essential coverage, but they differ in the cost sharing. Marketplaces also must make available minimum coverage plans, also referred to as catastrophic coverage plans, to people under age 30, as well as to individuals who are exempt from the mandate to purchase coverage because they have an affordability or hardship exemption. A minimum coverage plan covers minimum essential coverage, but only after out-of-pocket cost sharing reaches a high deductible that will match the level of the PPACNs required out-of-pocket maximum. Out-of-pocket costs for Covered California plans typically include:

- Coinsurance
- Co-payments or similar charges
- Deductibles

In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately?

California believes the annual allotments received were sufficient. Since Federal Fiscal Years (FFY) 2011, California's CHIP expenditures have been approximately equal to California's annual allocation. However, current estimates of FFY 2015 and beyond show expenditures depleting the annual allocation and all available prior year allotments. California believes that the current safeguards for redistribution and contingency funding will be sufficient to meet our future funding.

California's CHIP expenditures have averaged $1.24 billion in federal funds annually since 2006 and estimate an increase. in children covered with the implementation of PPACA. FFY 2014 expenditures are exceeded $1.4 billion in federal funds.

Without reauthorization, California will have several fiscal barriers:

1. Four of California's CHIP programs would lose $145 million in federal funding annually:
   a. Medi-Cal Access Program (Pregnant Women Unborn Option Coverage)
   b. Medi-Cal's Expansion Program for the Unborn Child Option
   c. Medi-Cal Access. Infant-linked Program
   d. C–CHIP

2. The remaining California CHIP programs would require coverage under Title XIX at a tower Federal Financial Participation and California would lose an additional $38 million in federal funds annually.

Additionally, the proposed PPACA Enhanced Funding for Children would enhance the CHIP federal matching rate by 23 percentage points beginning in October 2015. This enhancement would provide California with an additional $578 million in federal funds annually. However, an increase in the current allocation level would be required to maintain this enhanced level of funding through FY 2019.

Do you believe there is a need for Congress to further address the issue of unspent allotments?

No, California believes states are in a better position to address the issue of unspent allotments. The current process provides State's with the flexibility necessary given changes in health care and the economy which impact our expenditures.

STATE OF COLORADO

OFFICE OF THE GOVERNOR

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John W. Hickenlooper
GOVERNOR

October 31, 2014

The Honorable Fred Upton
Chairman
House Energy & Commerce Committee

The Honorable Ron Wyden
Chairman
Senate Finance Committee

The Honorable Henry Waxman
Ranking Member
House Energy & Commerce Committee

The Honorable Orrin Hatch
Ranking Member
Senate Finance Committee

Dear Congressmen:

We are grateful for the opportunity to respond to your letter regarding continued federal funding for the Children's Health Insurance Program (CHIP), dated July 29, 2014.

As detailed in the enclosed pages, Colorado's CHIP program—known locally as the Child Health Plan *Plus* (CHP+)—is a critical component of Colorado's commitment to ensure access to affordable and comprehensive health insurance coverage. We are proud to have made substantial progress in reducing the number of uninsured children in Colorado in recent years, and CHP+ continues to be a key driver of that success.

In light of ongoing changes to the coverage landscape due to both state and federal health reforms, we strongly encourage Congress to continue funding CHIP through 2019. We believe that this continued funding period best aligns with existing CHIP policy and will provide states the opportunity to analyze data and evaluate long-term coverage strategies that ensure individuals and families continue to have access to coverage and access to care.

We would be happy to provide you with any additional information about Colorado's CHIP program. Should you have any further questions, please reach out to our Washington, D.C. Liaison, Jena Griswold, at 202.624.5278 or jena.griswold@state.co.us.

Regards,

John W. Hickenlooper,
Governor

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics).

Colorado's CHIP program, the Colorado Child Health Plan Plus (CHP+), serves over 112,000 children and nearly 3,000 pregnant women living between 133% and 250% FPL—roughly $31,000 to $58,000 for a family of four, as detailed below. CHP+ is an HMO-model program administered by the Colorado Department of Health Care Policy and Financing, which also administers Colorado Medicaid and is the state's single state Medicaid agency. Core demographics for our CHP+ population are as follows: [1]

Distinct Clients FY 2013–14
July 2013–June 2014

Population	Distinct Clients
Children	112,395
Prenatal	2,853
Total	**115,248**

FY 2013–14 Distinct Client Ethnicity Distribution

Race	Children	Prenatal	Total
American Indian	1.82%	1.37%	1.81%
Asian	2.71%	2.75%	2.71%
Black	5.64%	5.46%	5.63%
Native Hawaiian/Pacific Islander	0.44%	0.33%	0.43%
Other	7.68%	9.85%	7.73%
Other—White	32.40%	49.83%	32.84%
Spanish American	31.80%	21.30%	31.54%
Unknown	17.52%	9.11%	17.31%

FY 2013–14 Distinct Client Distribution by Income

FPL	Children	Prenatal	Total
0%–100% FPL [2]	7.97%	17.06%	8.17%
101%–150% FPL [1]	22.67%	12.68%	22.45%
151%–200% FPL	34.47%	19.63%	34.14%
201%–205% FPL	4.47%	8.31%	4.55%
206%–250% FPL	22.60%	37.29%	22.92%
Blank	7.83%	5.02%	7.77%
Total	**100.00%**	**100.00%**	**100.00%**

Although our actuaries have access to beneficiaries' encounter data for rate setting purposes, Colorado does not directly collect information on CHP+ enrollees' health status. A sample of CHP+ beneficiaries' data provided by Colorado Access (the largest of our CHP+ carriers, with 37,000 members) indicates that 83 percent of the CHP+ insured population visited a primary care provider in the last year. Additionally, CHP+ children report better general health than uninsured and Medicaid populations, but worse health than commercially insured populations, as illustrated in the following table:

[1] Colorado Department of Health Care Policy and Financing, 2014.

[2] Colorado expanded Medicaid to all individuals with incomes 0–133% FPL in January 2014, and began to use the Modified Adjusted Gross Income (MAGI) eligibility determination criteria in October 2013. Some individuals in the 0–133% FPL income range are listed here because the time period shown partially predates our MAGI implementation. Additional detail can be found in the response to Question 2.

Self-Reported Health Status by Insurance Type, Children Ages 0–18, Colorado, 2013 [3]

	CHP+	Medicaid	Commercial Insurance	Uninsured
General Health Status				
Excellent/Very Good/Good	97.0%	90.6%	98.1%	95.2%
Fair/Poor	3.0%	9.4%	1.9%	4.8%
Oral Health Status				
Excellent/Very Good/Good	87.2%	93.6%	95.7%	84.2%
Fair/Poor	12.8%	6.4%	4.3%	15.8%
Mental Health Status				
Less than 8 poor mental health days	88.6%	87.5%	94.7%	87.5%
8 or more poor mental health days	11.4%	12.5%	5.3%	12.5%

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

Colorado has taken a measured, bipartisan approach to implementing the Patient Protection and Affordable Care Act (ACA). In doing so, we have built upon foundations that predate the ACA and passed bipartisan legislation that enabled us to expand Medicaid to 133% FPL and establish a state-based health insurance marketplace, Connect for Health Colorado (C4HC).[4] Pursuant to the ACA, HCPF began using Modified Adjusted Gross Income (MAGI) methodology to calculate eligibility for both Medicaid and CHP+. As part of that rule implementation, both programs use a 5 percent "income disregard" to assist families whose income is close to the eligibility cutoff under MAGI methodology. As such, we determine CHP+ eligibility for children and pregnant women if their income is less than 260% FPL.

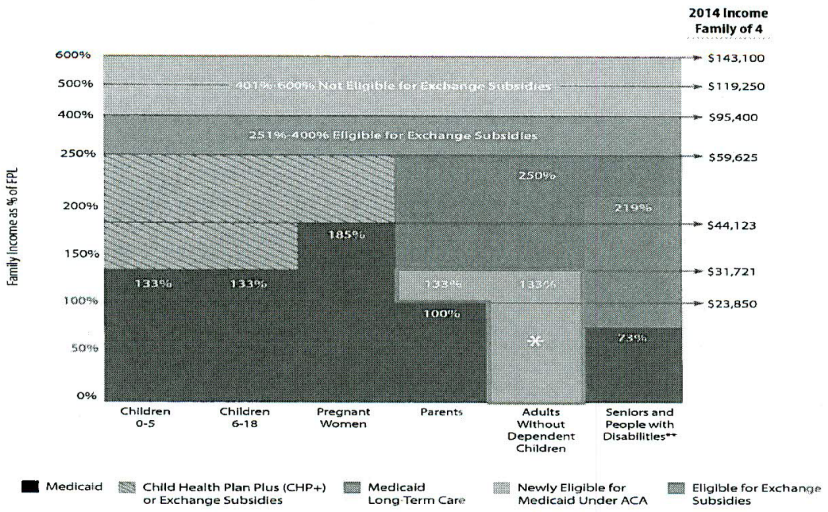
The following table provides an overview of coverage options for Coloradans at or below 400% FPL, as of January 2014: [5]

[3] Colorado Health Institute analysis of the 2013 Colorado Health Access Survey, 2014.

[4] Senate Bill 13–200 and Senate Bill 11–200, respectively. Senate Bill 13–200 codified in pertinent part at 25.5–4–402.3; Senate Bill 11–200 codified at 10–22–101, et seq.

[5] Source: Colorado Health Institute, 2014.

Eligibility Levels for Public Insurance Programs, by Population, Colorado, 2014



We have also taken steps to limit the impact of "churn" across various coverage programs to help improve continuity of care for Colorado individuals and families. For example, in March 2014, Colorado began providing twelve months of continuous eligibility for children in Medicaid and CHP+, even if the family experiences a change in circumstances that effect eligibility. This policy helps prevent lapses in continuity of care and is in place for 28 CHIP programs nationwide.[6] Although this was authorized by state law that predates the enactment or implementation of the Patient Protection and Affordable Care Act (ACA), implementation of the ACA resulted in changes to our financial models that enabled us to implement 12-month continuous eligibility for children.[7]

3. To the extent the following is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Colorado strives to improve continuity of care, to align benefits across Medicaid, CHP+, and qualified health plans (QHPs) purchased through C4HC, and to ensure our system works seamlessly for families and children. While CHP+ and private market individual insurance coverage have very similar benefits, cost sharing differs significantly. Specifically, average annual cost sharing in a QHP can be roughly four times cost sharing for CHP+, even after cost sharing reduction subsidies are accounted for.[8] Additionally, although both CHP+ and QHPs establish an out-of-pocket maximum, Colorado's CHP+ program establishes this maximum at 5 percent of the enrollee's income. In contrast, the out-of-pocket maximum for QHPs is a fixed dollar amount adjusted for low-income populations, which could be as high as $5,200 for some CHP+ families. For additional information on differences in benefits and cost sharing based on analysis conducted by Wakely Consulting Group, please see Appendix A.

Colorado's CHP+ program has been a successful safety net coverage program since its inception. As a testament to its success, in 2012, advocates successfully lobbied to gain access to CHP+ for dependent children of state employees.

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[6] Kaiser Family Foundation, State Health Facts. Accessed October 20, 2014. Available at: *http://kff.org/medicaid/state-indicator/12-mo-continuous-eligibilitymedichip/*.

[7] Colorado Health Care Affordability Act, House Bill 09–1293, codified in pertinent part at Colo. Rev. Stat. § 25.5–4–402.3.

[8] Wakely Consulting Group, "Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans," July 2014.

4. Do you recommend that CHIP funding be extended? If so, for how long and for budgeting and planning purposes, under what timeframe should congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many covered children by CHIP do you estimate would become uninsured in the absence of CHIP?

We appreciate Congress' desire to assess whether federal CHIP funding should be renewed in light of new coverage options provided by the ACA. At the same time, we are still implementing key provisions of the ACA that may have significant market impacts over time and alter the value proposition for maintaining the CHP+ program. Ultimately, our goal is to continue reducing the number of uninsured Colorado children while ensuring that coverage options remain affordable for low-income populations.

At this time, Colorado recommends CHIP funding be reauthorized for another four years to align with CHIP's existing maintenance of effort requirements. Given the current coverage opportunities available to our CHP+ population and our commitment to maintain market stability as we implement the ACA, we firmly believe that discontinuing federal CHIP funding in any less than four years would eliminate CHP+ as a coverage option for Colorado families and create a significant financial hardship for low-income Coloradans.

In addition to providing alignment with existing CHIP policy, a four-year funding reauthorization will enable states to monitor coverage trends and engage stakeholders around coverage alternatives to CHIP in the event Congress determines the CHIP program should not be reauthorized in the future. Any long-term changes to CHIP at the federal level are likely to necessitate program, policy, and legislative changes at the state level for which states must be given the opportunity to prepare.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

Since restructuring of the allotments occurred, Colorado has not utilized the full annual allotment of CHIP funding. Current funding levels have enabled us to achieve our CHP+ goal of providing coverage to pregnant women and children, and the funding that remains in Colorado's allotment provides a critical safety net for the CHP+ program, as it would provide a short-term funding source should Congress fail to reauthorize CHIP funding in 2015.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

Implementation of the ACA has enabled Colorado to provide coverage options for nearly all children in our state. We are also proud to have received over $157 million in CHIPRA performance bonuses since 2010 for our efforts to insure Colorado kids. However, to continue reducing the uninsured rate and maintaining continuity of coverage and care among children in our state, we need to align eligibility and enrollment policies across a broader range of social services.

Last year, Colorado launched Colorado PEAK—the Program Eligibility and Application Kit—an online portal allowing consumers streamlined access to and application for a variety of state benefits and services. By the end of 2014, up to 20 programs will participate in PEAK, including child care, nutrition, and energy assistance programs. To better serve families in need, Congress should work with federal agencies and willing states to align eligibility, enrollment, and renewal policies across social support programs, including Medicaid, SNAP, TANF, National School Nutrition Programs, the Child Care Subsidy Program, and others. This would reduce the administrative burden on each program and, more importantly, provide a simpler and more holistic approach for families.

APPENDIX A: COLORADO CHP+/QHP BENEFIT & COST SHARING COMPARISON

Excerpt from "Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans," Wakely Consulting Group, July 2014 [9]

Wakely Consulting Group

COLORADO

The following provides a comparison of the benefits and cost sharing provisions of plans available to low income children in the state's Children's Health Insurance Program (CHIP) compared to what would be available to them through the Health Insurance Exchange (assuming enrollment as an individual in the lowest cost silver plan). This appendix consolidates key results specific to the state. Please refer to the body of the report for methodology, assumptions, and limitations for each comparison.

Actuarial Value and Average Cost Sharing

The following table compares the average out of pocket costs (copayments, deductibles and coinsurance) for children enrolled in CHIP compared to the coverage that would be available through the Exchange (with cost sharing reduction subsidies).

Income Level Coverage	160% FPL CHIP	QHP	210% FPL CHIP	QHP
Actuarial Value	97.4%	86%–88%	95.3%	72%–74%
Enrollee Average Percent of Allowed Claims	2.6%	12%–14%	4.7%	26%–28%
Average Annual Cost Sharing	$90	$411–$480	$161	$891–$960

Out of Pocket Maximums

Member out of pocket costs are capped for coverage under both CHIP and plans offered on the Exchange, limiting the financial exposure to families with children who have high cost medical needs. The following compares the maximum out of pocket costs for the CHIP plans to that of Exchange coverage, assuming enrollment as an individual in a silver plan. The maximum out of pocket costs for CHIP differ by state and may be either $0 (e.g., the plan has no cost sharing), a fixed dollar amount, or a percent of income (with premiums also included in the maximum out of pocket amount). Where CHIP out of pocket costs are based on a percent of income, we have assumed a family of three and subtracted out the annual premium for one individual to get to an estimated out of pocket maximum for use of medical services.

Plan	Type of Maximum	160% FPL	210% FPL
CHIP	% of income	$925	$1,970
QHP	fixed dollar	$1,450	$4,750

Pediatric Dental and Vision Cost Sharing

The following highlights the cost sharing and limit differences for pediatric dental and vision benefits. These are not explicitly accounted for in the AV calculation, and can be material benefits for children.

Service	160% FPL CHIP	QHP	210% FPL CHIP	QHP
Routine Vision Exams	$5 copay	50% after deductible	$10 copay	50% after deductible
Eyeglasses Cost Sharing	No copay: $50–$150	50% after deductible	No copay: $50–$150	50% after deductible
Dental Checkup Cost Sharing	No copay	50% after deductible	No copay	50% after deductible

[9] Full report available at: *http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014.pdf.*

Benefit Coverage and Limits

The following table summarizes the coverage of core and child-specific benefits (as outlined below) for this state.

Type Benefit	of Total Benefits	CHIP Covered	Limited	Not Covered	QHPs (Based on EHB)		Not Covered
					Covered	Limited	
Core	**11**	**91%**	**9%**	**0%**	**91%**	**9%**	**0%**
Child-Specific	**14**	**36%**	**29%**	**36%**	**36%**	**29%**	**36%**

The following table shows the coverage and limits for the core benefits.

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Physician Services	C		C	
Clinic Services & Other Ambulatory Health Care Services	C		C	
Laboratory & Radiological Services	C		C	
Durable Medical Equipment & Other Medically-Related or Remedial Devices	L$	Certain items subject to $2,000 annual limit	C	
Inpatient Services	C		C	
Inpatient Mental Health Services	C		C	
Surgical Services	C		C	
Outpatient Services	C		C	
Outpatient Mental Health Services	C		C	
Prescription Drugs	C		C	
Medical Transportation—Emergency Transport	C		C	

The following table shows the coverage and benefit limits for child-specific benefits,

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Dental—Preventive & Restorative Services	L$	$600	C	
Dental—Orthodontics	U		U	
Vision—Exams	C		C	
Vision—Corrective Lenses	L$	$50/year	C	
Audiology—Exams	C		C	
Audiology—Hearing Aids	C		C	
ABA Therapy	U		LQ	550 sessions (age 0–8); 185 sessions (age 9–19) (25-minute session increments)

Service	CHIP Coverage	Limits	EHB Coverage	Limits
Autism—General	C		LQ	550 sessions (age 0–8); 185 sessions (age 9–19) (25-minute session increments)
Physical Therapy, Occupational Therapy, and Speech Therapy	LQ	No limit (age 0–3) 30 visits/year (per diagnosis, age 3+)	LQ	20 visits/year (per type of therapy)
Podiatry	LC	Routine foot care not covered except for patients with diabetes	U	
Habilitation	C		LQ	20 visits/year (per type of therapy)
Enabling Services	U		U	
Medical Transportation—Non-Emergency Transport	U		U	
Over-the-Counter Medication	U		U	

Dannel P. Malloy
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STATE OF CONNECTICUT

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October 30, 2014

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate
104 Hart Office Building
Washington, DC 20510

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
United States House of Representatives
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
United States House of Representatives
2204 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Wyden and Upton, and Ranking Members Hatch and Waxman:

Thank you for your letter of July 29, 2014, concerning the Children's Health Insurance Program (CHIP). I appreciate the opportunity to address the merits of and continued need for federal funding for this vital program.

Connecticut has made it a priority to ensure that all of its citizens have access to high quality and affordable health insurance. Connecticut's state-based health insurance exchange, Access Health CT, enrolled over 200,000 people during the first open enrollment period. This reduced Connecticut's rate of uninsured from 7.9% in 2012 to 4%—one of the ten largest reductions in the country. Over 80% of these new enrollees qualified for Medicaid. Connecticut Medicaid is now serving almost 770,000 individuals, over 2l% of the state population.

Connecticut's CHIP, which is known as HUSKY B, is an essential source of coverage for 14,119 children under age 19. Additionally, the program provides federal match

for additional income-eligible children in Connecticut's coverage group for children and relative caregivers, which is known as HUSKY A. CHIP provides a broad range of preventative care, behavioral health, and dental services that support Connecticut children in early childhood development, school readiness and performance, and overall well-being.

I have provided below our responses to the six questions that you raised in your letter.

1. How many individuals are served by your state's CHIP Program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

Connecticut is currently covering 14,119 children in CHIP/HUSKY B. The PPACA Modified Adjusted Gross Income (MAGI) conversion increased the maximum income eligibility limit for HUSKY B from 300% to 323% of the Federal Poverty Level (FPL). Additionally, Connecticut permits families with income in excess of 323% of FPL to purchase coverage via monthly premiums. The distribution of participants across Connecticut's three "bands" of coverage is depicted below:

HUSKY B premium band	Annual income level as % of FPL	Annual income level in dollars (family of four)*	Premiums	Annual out-of-pocket maximum	Number of participants
Band 1	201% to 254%	$47,938–$60,578	None	5% of gross income	8,941
Band 2	254% to 323%	$60,579–$77,035	Maximum $30 for one child, $50 for two or more children per month	5% of gross income	4,805
Band 3	Above 323%	Above $77,035	$314 per child per month	No cap	373

*As of July 1, 2014, Connecticut's annual poverty level for a family of four is $23,850. See: *http://www.ct.gov/dss/lib/dss/PDFs/PovSMI.pdf.*

This is the HUSKY B enrollment by band as reported by Xerox as of October 1, 2014:

	Band 1	Band 2	Band 3	Grand Total
Total Enrollment by Premium Band	8,941	4,805	373	14,119

HUSKY B coverage is contributing to significant improvements in health outcomes for enrolled children. Under Connecticut's unique, self-insured managed fee-for-service system, the following results were achieved for calendar year 2013:

- increased well-child visits in the first 15 months of life (six or more visits) by 13.5%;
- increased well-child visits in the third, fourth, fifth and sixth year of life by 4%;
- increased access to primary care practitioners for children age 12–24 months by 4% to 99.5%;
- increased access to primary care practitioners for children age 25 months to 6 years by 3% to 97%;
- increased immunization rate for adolescents (Tdap/Td Total) by 7%;
- increased lead screening in children by 21.5%; and
- increased number and percentage of children age 3 to 19 who received preventive dental care to 69% (HUSKY A) and 73% (HUSKY B).

The demographics of children served by CHIP/HUSKY B are as follows:

- 48.2% are female and 51.8% are male;
- 10.1% identify as African-American;
- 22.5% identify as Hispanic; and
- 70.6% identify as Non-Hispanic White.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

The PPACA Modified Adjusted Gross Income (MAGI) conversion increased the maximum income eligibility limit for HUSKY B from 300 to 323% of the Federal Poverty Level (FPL). Additionally, Connecticut availed itself of the option to eliminate the crowd-out for coverage.

3. To the extent the following information is readily available and you believe that it is relevant, please describe the services and or benefit and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

CHIP/HUSKY B provides a much broader range of behavioral health benefits than do exchange and employer-sponsored health plans. Additionally, CHIP/HUSKY B covers dental services with among the best geo-access of Medicaid programs in the country. Dental services are only covered through the exchange through purchase of stand-alone plans, and are typically covered by employer-sponsored health plans on a much more limited basis. There are no monthly premiums and a limitation on annual out-of-pocket costs of 5% of gross income in Connecticut's Band 1 for CHIP coverage; and a modest monthly premium of $30 for one child and $50 for two or more children, and a limitation on annual out-of-pocket costs of 5% of gross income in Connecticut's Band 2. These modest cost-sharing obligations (low if any premium, no deductible, limitations on out-of-pocket costs) are substantially less than would be paid for a Connecticut Qualified Health Plan (QHP).

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe that CHIP funding should be extended, what coverage (if any) do you believe that CHIP enrollees in your state would be able to obtain? How many children covered by CHIP would become uninsured in the absence of CHIP?

CHIP funding should be made permanent. Over the course of its existence, CHIP has proved to be a critical source of support for hundreds of thousands of children nationwide. The current cost-sharing arrangement between the federal government and the states represents an appropriate balancing of interests in the health, safety, and well-being of our children.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

Connecticut's current CHIP expenditures are at levels that will fully utilize an amount equal to our annual allotment of funding. This has been the case for the past several fiscal years. That said, there is also an ongoing balance of funds that have been carried forward from years prior that affects the manner in which Connecticut accesses its federal funds, resulting in a carry-forward from year to year.

To the extent that there are states that are unable to expend their allotments, Congress could adopt a distribution methodology that examines expenditures year over year and makes appropriate adjustments based on demonstrated need.

6. Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that can help states do an even better job of enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?

Connecticut has been demonstrably successful though both its CHIP/HUSKY B program and Access Health CT enrollment activities in reducing the incidence of uninsured children in Connecticut. With respect to CHIP, the single most effective support for enrollment and continuity of care for children served by CHIP will be extension of federal CHIP funding. Additionally, performance bonuses have effectively

incented and rewarded states that have (1) met their target for enrollment; and (2) implemented at least five of eight identified policies that support timely access to and maintenance of CHIP coverage (12-month continuous coverage; either no asset test or simplified asset verification; no face-to-face interview requirement; joint application and consistent information verification processes across Medicaid and CHIP; administrative or *ex parte* renewals; presumptive eligibility; express lane eligibility; and premium assistance option). Connecticut has qualified in Federal Fiscal Years 2011 ($5.2 million), 2012 ($3.0 million) and 2013 ($1.6 million) for CHIPRA performance bonuses. Over and above activities related to Medicaid, Congress could support access to and adequacy of coverage under QHPs by:

- examining the incidence of families affected by the "family glitch" and considering appropriate remedies;
- reviewing the cost effectiveness, network adequacy and scope of coverage of QHPs with respect to supporting the needs of children and Families; and
- providing ongoing support for the in-person assister functions that have been funded under PPACA.

Thank you for the opportunity to share our perspective. Continued funding for CHIP is essential. Failure to preserve CHIP funding will jeopardize continued coverage for children in demonstrated need for these supports and necessarily expose states to significant budget constraints. I respectfully request that you make resolution of this pending issue a high priority.

Sincerely,

Dannel P. Malloy,
Governor.

Delaware Health and Social Services
Office of the Secretary

1901 N. DUPONT HIGHWAY, NEW CASTLE, DE 19720 • TELEPHONE: 302–255–9040 FAX: 302–255–4429

November 3, 2014

The Honorable Fred Upton
Chairman
U.S. House of Representatives
Committee on Energy and Commerce
Congress of the United States
Washington, DC 20515

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
Congress of the United States
Washington, DC 20515

The Honorable Henry A. Waxman
Ranking Member
U.S. House of Representatives
Committee on Energy and Commerce
Congress of the United States
Washington, DC 20515

The Honorable Orrin G. Hatch
Ranking Member
U.S. Senate
Committee on Finance
Congress of the United States
Washington, DC 20515

Thank you for the opportunity to comment on the Children's Health Insurance Program (CHIP) as you consider an extension of funding beyond FY 2015. CHIP has been an integral component of the health safety net for children in low-income families since its enactment in 1997.

1. **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state?**

   14,612 children were enrolled in Delaware's CHIP program during State Fiscal Year 2014 (July 2013–June 2014). This represents an unduplicated count of children who were enrolled at any point during the year.

   Demographic characteristics of the children can be found in the tables below.

	Number	Percent
Gender:		
Male	7,387	50.5%
Female	7,225	49.5%

	Number	Percent
Age:		
Under 5	2,677	18.3%
5–8	3,650	25.0%
9–12	3,530	24.2%
13–15	2,516	17.2%
16–18	2,239	15.3%
Income:		
100%–150% FPL	7,958	54.5%
150%–200% FPL	6,654	45.5%

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

Very few substantive changes were made to the Delaware CHIP program as a result of PPACA. CHIP and Medicaid are administered by the same agency, the Division of Medicaid and Medical Assistance, and CHIP offers the full range of services covered under EPSDT. Eligibility and enrollment are integrated and children are served by the same Managed Care Organizations (MCOs).

Changes made as a result of PPACA include adoption of MAGI eligibility rules and transition of children between 100%–133% of FPL from CHIP to Medicaid. Children who transitioned to Medicaid will no longer be subject to a monthly premium and will now have access to the non-emergency transportation benefit.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Cost sharing for families of children enrolled in CHIP is very minimal. The maximum family premium is $25 per month. There are no additional co-pays with the exception of a $10 charge for non-emergency visits to the emergency department. Since the full range of EPSDT covered services is available to the CHIP population, these children also have access to dental and specialized services that might not be available in exchange or employer-sponsored health plans.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to attain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

Yes, CHIP continues to provide a critical health care safety net for children. Funding should be extended to align with the current authorization ending in 2019. Discontinuation of funding could result in various scenarios depending on the structure of a state's CHIP program. Delaware administers a combination CHIP program with both a Medicaid expansion component and a stand-alone component.

Children enrolled in the CHIP Medicaid Expansion would continue to receive services but the state would receive the lower Medicaid FMAP rather than the CHIP enhanced EFMAP. The state would be required to meet MOE requirements for the stand-alone component. Beyond that, without an infusion of state funds, families would need to purchase insurance through the marketplace. This would likely present a financial burden for some families. There is also the concern that some children would not be eligible for marketplace coverage due to the "family glitch" in the affordability test.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you be-

lieve there is a need for Congress to further address the issue of unspent allotments?

Annual allotments have been sufficient to cover the federal portion of CHIP expenditures. It remains to be seen whether states will benefit from the PPACA FMAP increase without an extension of funding and review of the funding methodology.

6. **Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improved health outcomes for children in your state?**

Delaware is actively engaged in promoting health innovation and transformation. As these efforts roll out, it will be necessary to critically assess the roles and value of each program with the goal of greater integration and alignment. CHIP currently provides a critical bridge between Medicaid and the marketplace but that need may diminish over time. It is also essential to more seriously consider all factors which impact health outcomes for children, including social determinants of health. Increased coordination and alignment of eligibility policies between federal agencies would strengthen the financial, nutritional, housing, and social supports necessary for children in low-income families.

Thank you,

Rita M. Langraf,
Secretary

STATE OF GEORGIA

OFFICE OF THE GOVERNOR
ATLANTA 30334–0900

Nathan Deal
GOVERNOR

November 20, 2014

The Honorable Ron Wyden, Chairman
Senate Finance Committee
221 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Orrin G. Hatch, Ranking Member
Senate Finance Committee
104 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Fred Upton, Chairman
House Committee on Energy and Commerce
2183 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Henry A. Waxman, Ranking Member
House Committee on Energy and Commerce
2204 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairmen Wyden and Upton and Ranking Members Hatch and Waxman:

On behalf of the State of Georgia, I would like to thank you for the opportunity to provide state-level input as Congress considers the future of the Children's Health Insurance Program (CHIP). I am writing to respond to the questions outlined in your July 29, 2014 letter regarding the Children's Health Insurance Program in Georgia which is also known as PeachCare for Kids®. As a state-established program, funded jointly between federal and state governments, your request for input

from the state of Georgia, on behalf of nearly 200,000 children this program covers in our state, is greatly appreciated.

1. How many individuals are served by your state's CHIP program? What are the characteristic of CHIP enrollees in your state (e.g. income, health status, demographics)?

Response: In August 2014, 196,996 children were enrolled in the PeachCare for Kids® program. As renewals are completed monthly, some children have been found to be eligible for the Medicaid program, and they have been transferred to the Title XIX program. We expect a monthly decrease of 3,000–4,000 children until December 2014.

In terms of demographics, the following tables depict race, gender, and household income data that you may find helpful.

Count of RACE

	F	M	Grand Total
American Indian or Alaska Native	107	94	201
Asian	4,519	4,736	9,255
Black or African American	31,198	31,907	63,105
Hispanic or Latino	14,477	15,034	29,512
Native Hawaiian or Other Pacific Islander	56	64	120
None	7,974	8,115	16,089
Not Specified	77	80	157
Other	6,536	6,840	13,376
White	39,342	42,119	81,461
Grand Total	**104,286**	**108,989**	**213,276**

The household income breakdown for members enrolled in the Georgia CHIP program in June 2014 is included in the table below.

Yearly Household Income	Count
$0–10,000	97
$11,000–20,000	14,929
$21,000–30,000	44,448
$31,000–40,000	37,175
$41,000–50,000	17,446
$51,000–60,000	6,113
$61,000–70,000	1,452
$71,000–80,000	295
$81,000–90,000	69
$91,00 and up	59

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

Response: Georgia took several actions that were required as a result of the Affordable Care Act (ACA). Note that these changes required significant additional state resources and extensive modifications to existing computer systems.

a. Georgia was required to lower premiums due to the income/federal poverty level conversions required by the Act.
b. Georgia implemented a single application for Medicaid, PeachCare for Kids and other public assistance programs. Individuals wishing to apply may now apply through a single electronic portal. Should individuals choose to apply via paper, the paper application now used by the program is based on the streamlined application created by the Centers for Medicare and Medicaid Services (CMS).
c. Georgia was required to remove the requirement that families returning to CHIP eligibility due to nonpayment of premiums pay back past due premiums in order to be eligible for CHIP.

d. As a result of ACA, we have begun and will continue the move of an estimated 58,000 children from CHIP to the Medicaid program through December 31, 2014. These are children who are between 100–133% of the federal poverty level.
e. The eligibility determination process for CHIP has been moved to a Modified Adjusted Gross Income (MAGI) methodology. States were required to adopt MAGI rules to determine income in order to align with rules used for premium tax credits available through the exchanges.
f. The CHIP program implemented a 45-day standard of promptness for completion of applications in order to align with the Medicaid program and comply with new regulations.
g. Consistent with Section 10203(b)(2)(D) of the Act, Georgia modified CHIP eligibility criteria to permit enrollment of low-income children of state employees who are otherwise eligible under the state employees' health insurance plan.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Response: Georgia has not completed a comparison of the services, benefits, or cost sharing available through our CHIP program to the exchange plans.

However, several organizations have completed reports that include a comparison of Georgia's CHIP program to Exchange plans.

The Robert Wood Johnson Foundation issued a report[1] in July 2014 that was completed by Wakely Consulting Group that included a comparison of Exchange plans available in Georgia to the PeachCare for Kids (CHIP) program. They concluded that the Actuarial value of Georgia's CHIP plan is 99.3% with an average annual cost sharing of $24.00 when compared at 160% and 210% of the FPL.

The National Alliance to Adolescent Health also completed a study[2] that compared Georgia's plan to exchange plans. They concluded that Georgia's CHIP coverage is much more affordable and provides a broader set of benefits than subsidized silver plans sold in the federal exchange. For your comparison purposes, the premium cost per month for PeachCare for Kids® coverage is $0 to $35 for one child and a maximum of $70 for two or more children living in the same household. There is no cost for coverage for children under age 6. Additionally, co-pays range from $0 to $15.00 depending on the service provided and the age of the child. There are no copays for preventive care services, including well child visits. Federal requirements limit out of pocket costs for CHIP to be no more than 5% of household income, including premiums and co-pays.

The aforementioned studies, as previously noted, were completed by third party organizations and their findings have not been validated by the State of Georgia.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

Response: Children covered through CHIP could be enrolled in other insurance through the federal exchange. The exchange plan must be comparable to CHIP and be approved by the Secretary of Health and Human Services. To date, the Secretary has not certified such a plan. Also, the exchange is only

[1] Wakely Consulting Group, A.B. (2014, July). Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans. Retrieved August 1, 2014, from Kaiser Health News: *http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf.*

[2] Fox, M.M. (2014, July). The National Alliance to Advance Adolescent Health. Retrieved August 7, 2014, from thenationalalliance.org:*http://www.thenationalalliance.org/index.cfm.*

an option if the child's parent does not have access to affordable employer-sponsored insurance.

Until such time that the Secretary identifies comparable plans, the disparity between the CHIP premiums and copayments and their impact on enrollment remains unknown. Therefore, an estimate of the number of children that would be uninsured is difficult to determine at this time. However, we do know that today some families have difficulty paying the relatively low cost-sharing for the CHIP program, and we project that approximately 170,000 children would lose CHIP coverage in Georgia if the program ended at this time.

The ACA required children 100%–138% of FPL to be covered by Medicaid. This population is sometimes referred to as "stair step kids." In Georgia, these children were previously covered under our CHIP program, PeachCare for Kids®. Though this is a mandatory expansion of Medicaid, CMS allowed states to continue to draw the enhanced CHIP federal match for the stair step population even though they are enrolled in Medicaid. The end result was that moving this population to Medicaid had no cost impact to the state.

If Congress were to discontinue the CHIP program, they would need to either: (1) remove the requirement that Medicaid cover kids up to 138% of FPL; or (2) continue the enhanced FMAP for the stair step population.

Consistent with the recommendations of the Medicaid and CHIP Payment Access Commission (MACPAC), an additional two (2) years of funding would provide benefits which include but may not be limited to: (1) ensuring continued access for children who may otherwise become uninsured due to increased premiums and/or patient co-payments; (2) providing sufficient market place experience with exchange plans delivery of healthcare services to children to assess comparability; and (3) give states adequate time to prepare for the ending of the program, and to assist with the transition of CHIP members to an exchange plan. A critically important factor Congress should consider is need for sufficient time for states to phase down the program and work toward a smooth transition for these children. Therefore, states need the earliest decision possible from Congress on the direction of this program.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

Response: To date, the funding formula has worked appropriately for Georgia and we do not see a need for Congress to address the issue of unspent allotments at this time.

6. Over the past number of years, States have worked to reduce the number of uninsured children and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

Response: There are several federal policy changes that would be helpful.

A. Permit individuals to seek coverage and subsidies on the exchange if the employer's offer of *family* coverage exceeds 9.5% of family income. The ACA requires that premiums for *individual* coverage not exceed 9.5 percent of household income, but there is no limit on the employee's share of premiums for *family* coverage. Considering the cost of *family* coverage as a percentage of family income as criteria for accessing coverage through a subsidized plan via the exchange should be considered. Otherwise, the cost of family coverage may cause many to opt out of providing coverage for their children.

B. Permit federal subsidies for people with incomes below 400 percent of the federal poverty level. These subsidies are not currently available for anyone who receives an offer of insurance from an employer. That means workers who can't afford employer-offered premiums for family coverage now have nowhere to go except the Children's Health Insurance Programs (CHIP) or Medicaid, if they qualify. Congress should consider expanding Premium As-

sistance approaches to assist families in purchasing employer-sponsored coverage for children and their parents as an alternative to CHIP. We believe maintaining coverage as a family unit—rather than approaches that split parents and children—is a preferable approach and is beneficial to the family.

C. Change *Vaccines for Children (VFC)* rules for CHIP to match Medicaid rules, so that they are the same for all CHIP and Medicaid programs. Children enrolled in a stand-alone CHIP program are not eligible to receive VFC stock because the children are considered insured. Children enrolled in a Medicaid expansion CHIP model are eligible to receive VFC stock because they are considered to be Medicaid eligible. The current rule creates administrative and access barriers to vaccines while disadvantaging certain states like Georgia who have established separate CHIP programs.

Again, Georgia appreciates the opportunity to provide our thoughts on the future direction of the CHIP program. As Congress evaluates various options going forward, please do not hesitate to let me know if you have any questions or concerns. For any follow up inquiries please contact Clyde Reese, Commissioner, Department of Community Health.

Sincerely,

Nathan Deal

State of Hawaii

EXECUTIVE CHAMBERS

HONOLULU

NEIL ABERCROMBIE
GOVERNOR

October 10, 2014

The Honorable Fred Upton
The Honorable Henry A. Waxman
The Honorable Ron Wyden
The Honorable Orrin G. Hatch
2183 Rayburn House Office Building
Washington, D.C. 20515

Dear Congressman Upton, Congressman Waxman, Senator Wyden, and Senator Hatch:

This letter is in response to the questions posed regarding the Children's Health Insurance Program (CHIP) in your July 29, 2014 letter. CHIP is an immensely valuable program for reducing the rate of uninsured children. According to the U.S. Census Bureau Current Population Survey 2013 Annual Social and Economic Supplement, Hawaii had an uninsured children rate of 3.6%, one of the lowest in the nation. CHIP, which provides health care coverage to 28,230 children in Hawaii, plays an important role assuring access to health care for Hawaii's children.

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

As of June 2014, 28,320 children, of which 88 were blind or disabled, benefited from Hawaii's CHIP program. The distribution of eligible children by island of residence is 57% Oahu, 18% Hawaii, 14% Maui, 9% Kauai, and 1% Molokai/Lanai. Of the eligible children statewide, 1% were age <1 year, 19% age 1–5 years, and 80% age 6–19 years. Distribution by household income is provided in the table.

% FPL	#	%
<150	575	2.0%
150 to <200	53	0.2%
200 to <250	21	0.1%
250 to <300	27,671	97.7%

% FPL	#	%
Total	28,320	100.0%

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

Hawaii has implemented CHIP as a Medicaid expansion program. As such, the two programs are fully integrated from an operational perspective. Hawaii has implemented changes specifically required under the ACA (e.g., provider enrollment and screening), and has successfully implemented a new eligibility system with online application capability and interface to the federal services data hub. The implementation of PPACA has otherwise not impacted Hawaii's administration of its CHIP program.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Children in Hawaii covered under CHIP receive full Medicaid state plan benefits, including EPSDT, which meet minimal essential coverage and are comparably or more available compared to commercial health plans available in the State. Hawaii's CHIP has no cost sharing.

I strongly support extending the enhanced reimbursement in Medicaid, expanding provider eligibility to other key specialties and provider types, and extending these initiatives to all of CHIP or at least to Medicaid expansion CHIP. Commercial health plans reimburse providers at a higher rate. The reimbursement enhancement to primary care providers in Medicaid has been valuable, but this provision did not extend to CHIP. This has been challenging in states, like Hawaii, that have implemented CHIP as a Medicaid expansion as it has been difficult to implement the enhancement for primary care providers but not for CHIP providers as Hawaii does not have a separate CHIP program.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

No child should be without health insurance, and I strongly recommend that CHIP funding be extended. To avoid any gap in program continuity and provide stability to states, funding should be established prior to expiration of the current funding and for a period of no less than two years, preferably ten years.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

The CHIP funding for Hawaii has been sufficient.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?

Looking at the federal funding given to health insurance exchanges for outreach as precedent, providing 100% federal funding to states for outreach to identify and enroll uninsured children would be beneficial. For younger children, increased federal funding could be made available to public health agencies to incorporate health insurance tracking and application assistance with immunization efforts. For school age children, schools in receipt of federal funding could be required to verify that students have health insurance, and schools could be

required and/or given the authority to submit an application for affordable health insurance on behalf of an uninsured student.

Thank you for the opportunity to communicate my complete support for continued funding for the CHIP program and for other efforts to reduce the rate of uninsured children. If you have any questions regarding these responses, please contact our State Medicaid Director, Dr. Kenneth Fink.

Neil Abercrombie,
Governor, State of Hawaii

c: Patricia McManaman, (OHS, Director)
Kenneth S. Fink, MD, MGA, MPH, (DHS, MQDA)

The State of Idaho

C.L. "BUTCH" OTTER
Governor

November 10, 2014

Congressman Fred Upton
House Committee on Energy and Commerce
2183 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Upton,

Thank you for your recent letter about the Children's Health Insurance Program (CHIP). Idaho has partnered with the Centers for Medicare and Medicaid Services (CMS) since 1997 to provide healthcare coverage for eligible Idaho children.

I am aware that the existing funding authority under CHIPRA for the CHIP Program is ending, and I appreciate your inquiry seeking specifics about our program here in Idaho. My responses are below.

(1) How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

(a) Idaho had 25,518 children enrolled in our SCHIP program as of the end of FFY13.

(b) Idaho 's CHIP income cap is 185 percent (plus 5-percent disregard) of the federal poverty guidelines. CHIP enrollees are primarily Caucasian, tend to live in the largest urban areas of Idaho and are of good health status.

(2) What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

(a) In accordance with the PPACA, Idaho changed our income and eligibility methodology to use the Modified Adjusted Gross Income (MAGI) basis and moved children to our Title XIX program, effective January I, 2014.

(b) Idaho's administration of CHIP was impacted by the changes indicated above which required extensive modifications to our automated eligibility and claims systems. Idaho expects to exhaust all of our CHIP allotment this year.

(3) To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Children enrolled in Idaho's CHIP program have the same benefits as children enrolled under the Idaho Medicaid State plan. Idaho's CHIP program provides some benefits typically not provided through exchange or Employer Sponsored Insurance (ESI) plans such as: disposable medical supplies, hospice, case management for

children with special health care needs, dental care, Early Periodic Screening Diagnosis & Treatment services (EPSDT) and enabling services such as translation and medical transportation.

Idaho's CHIP children are subject to $3.65 copays for some, but not all services, which is about 60 percent less than co-pays provided through gold plans on our exchange or through ESI plans. Premiums for CHIP children are $15 or less per month. This also is significantly less expensive than exchange or ESI plans. CHIP children are not subject to deductibles, out of pocket maximums or lifetime benefit limitations, which are integral parts of exchange and employer sponsored plans.

(4) Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what time frame should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

Yes, I do recommend that CHIP funding be extended. Extending the funding through 2019 as a transition period would allow for key issues regarding the affordability and adequacy of children's coverage on the exchange to be addressed. Provisions in the current law that make it difficult for families to affordably maintain a single source of coverage should be addressed. We do not have a good estimate of the number that would become uninsured at this time.

(5) In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

(a) Yes, the annual allotment Idaho has been receiving in recent years has been sufficient to meet our needs.

(b) Yes. Adjusting to allow greater flexibility for states would be a positive measure to allow states to improve management and planning for their CHIP programs.

(6) Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been critical components of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

Yes, there are federal policy changes that could assist Idaho families in providing health coverage for their families.

- *Make CHIP look like an insurance plan (rather than an entitlement plan) by removing entitlement assurances like EPSDT and non-emergency medical transportation.*
- *Allow parents to have the option of choosing between premium subsidies on the exchange or subsidies for ESI coverage. These changes would allow families to choose a family plan through the marketplace or ESI and would improve continuity of care for the entire family and would avoid placing family members on separate health plans with separate provider networks and/or cost sharing requirements. Traditional insurance plans can do a better job managing premium/co-pay requirements.*

Thank you for the opportunity to share the specific details of Idaho's CHIP program. If you need any additional information regarding our program, please contact my CHIP Director, Matt Wimmer.

As Always—Idaho, "Esto Perpetua"

CLO/tp

C.L. "Butch" Otter
Governor of Idaho

cc: Congressman Henry Waxman

STATE OF ILLINOIS

OFFICE OF THE GOVERNOR

SPRINGFIELD, ILLINOIS 62706

Pat Quinn
GOVERNOR

October 24, 2014

The Honorable Fred Upton
House Committee on Energy and Commerce

The Honorable Henry A. Waxman
House Committee on Energy and Commerce

The Honorable Ron Wyden
Senate Finance Committee

The Honorable Orrin G. Hatch
Senate Finance Committee

Re: Children's Health Insurance Program (CHIP)

Dear Honorable Members of Congress:

Thank you for offering this opportunity to express Illinois' strong support for the continuation of the federal Children's Health Insurance Program.

CHIP has played a key role in Illinois' efforts to provide health coverage to hundreds of thousands of children and pregnant women since the inception of our first expansion of coverage in 1998. Not only has CHIP enabled Illinois to expand coverage to children in families with income above our Medicaid income level, the outreach activities and streamlined application processes resulting from CHIP have had important spillover effects by facilitating enrollment of eligible children in Medicaid.

The close integration of CHIP funded coverage with Medicaid coverage has allowed Illinois to provide a safety net of health coverage to uninsured Illinois children for more than 15 years. Illinois was one of the first states to cover a broad demographic of uninsured children including non-citizen children and children in families at higher income levels. As a result of our approach, over the past five years Illinois has received over $60 million in bonus payments under the Children's Health Insurance Program Reauthorization Act of 2009. We understand we are one of only nine states to receive bonus payments for five consecutive years.

As a result of changes required by the Affordable Care Act and with CHIP and Medicaid support, Illinois now covers children with family income up to 318 percent of the federal poverty level guidelines.

Responses to your specific questions follow.

1. *How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g., income, demographics)?*

CHIP funding contributes to Illinois' coverage of approximately 219,000 children and pregnant women as of June 30, 2014.

Illinois uses the CHIP "unborn" group to cover pregnant women who are not eligible to enroll in Medicaid and their children for the first few months of the children's lives. The unborn group included a total of about 38,000 individuals on June 30, 2014: 12,000 pregnant women and 26,000 infants. All of these individuals live in families with income no greater than 213 percent of the Federal Poverty Level (FPL) guideline. They have no cost-sharing obligations for services.

Of the 181,000 children not in the unborn group, about 50 percent have family income falling into the lowest CHIP funded plan which is our Medicaid expansion. They have no cost sharing for services. Of the remaining 91,000 children, about 14 percent pay modest co-payments for most services not including well-child care and about 36 percent pay small monthly premiums in addition to co-payments for services.

Of the 207,000 CHIP-funded children enrolled in Illinois on June 30, 2014 (including the 26,000 infants mentioned above), 25 percent are age 5 or younger, 41 percent are ages 6 through 12 and 34 percent are ages 13 through 18.

The majority of enrollees, 73 percent, live in Cook County and the five counties neighboring Cook. About 10 percent live in the northwestern region of the state and about 17 percent live in central and southern Illinois.

Of those who reported their race, 48 percent self-identified as White of whom 26 percent reported Hispanic/Latino ethnicity; 10 percent self-identified as Black or African American of whom 2 percent reported Hispanic/Latino ethnicity; 5 percent self-identified as Asian of whom 2 percent reported Hispanic/Latino ethnicity; fewer than 1 percent self-identified as Hawaiian/Other Pacific Islander of whom 26 percent reported Hispanic/Latino ethnicity; fewer than l percent self-identified as American Indian/Alaska Native of whom 46 percent reported Hispanic/Latino ethnicity; and 1 percent self-identified as multiracial of whom 14 percent reported Hispanic/Latino ethnicity. Of the 35 percent of enrollees who did not answer the race question, 72 percent reported Hispanic/Latino ethnicity. Of the total population, 12 percent reported Hispanic/Latino Ethnicity. Eighteen percent of the population failed to report any race or ethnicity.

2. *What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?*

While technically Illinois has implemented CHIP through a combination Medicaid expansion and separate CHIP program, the "separate" program is highly integrated with Medicaid and has been since its implementation in Illinois in 1998. Largely for that reason, Illinois had to make few changes in the administration of CHIP as a result of enactment of the ACA. The most significant change required was the adoption of the Modified Adjusted Gross Income or "MAGI" methodology for determining eligibility. This required converting our CHIP income standards to eliminate the state specific income disregards that we had previously employed.

3. *To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.*

Illinois' separate CHIP coverage is administered under the umbrella of All Kids, our array of plans for children. For CHIP eligible children, All Kids offers more robust benefits than those available through the Health Insurance Marketplace and All Kids' cost sharing requirements are more affordable.

The fundamental difference between services covered under All Kids and services covered by the benchmark plan for qualified health plans available through the Marketplace in Illinois is the availability of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits. Illinois has always offered our CHIP eligible children the same EPSDT services required for Medicaid eligible children. EPSDT coverage includes all screening, prevention and medically necessary diagnostic and treatment services falling with in the federal definition of Medicaid. EPSDT benefits include dental, vision and hearing services. No similarly broad coverage is found within the Marketplace benchmark plan, nor are we are aware of any comparable coverage offered by employer-sponsored plans in Illinois.

Premium and cost sharing limits in Illinois' All Kids are much lower than what is allowed in the Marketplace plans at equivalent income levels. We believe the same holds for children enrolled in employer-sponsored plans. For children in All Kids whose services are funded with CHIP dollars, monthly premiums range from $0–40 per child with a maximum of $80 per month for two or more children, and cost sharing for office visits ranges from $3.90–$15 per visit. Appropriate emergency room visits require no co-payment. On the Marketplace in 2014, the lowest cost bronze plan in Chicago for one child has a monthly premium of $76 per month and a$6,000 deductible. The lowest cost silver plan has a monthly premium of $105 per month, a $6,000 deductible, and a $30 co-pay for a primary care doctor, $50 co-pay for a specialist, and $500 co-pay for an emergency room visit. Similarly, in Peoria, the lowest cost bronze plan for one child has a monthly premium of $81 per month with a $6,300 deductible. The lowest-cost silver plan has a premium of $108 per month with a $3,750 deductible and a $10 co-pay for a primary care doctor, $75 co-pay for a specialist, and $500 co-pay for an emergency room visit.

Financial help is available on the Marketplace through premium tax credits and cost-sharing reductions, but All Kids is less expensive. For example, All Kids covers children in families with income up to 318 percent of the federal poverty level guidelines in Illinois. On the Marketplace at 300 percent FPL, families are expected to contribute 9.5 percent of their household income toward the benchmark plan's premium and no cost-sharing reductions are available. Even at 200 percent FPL on the Marketplace, the household is expected to contribute 6.3 percent of their household income toward the benchmark plan and, with cost-sharing reductions, a consumer has to cover 27 percent of the cost of benefits, on average.

Additionally, on the Marketplace, financial help is only available to consumers without alternative minimum essential coverage (MEC). Under IRS regulations, if an employee receives an affordable offer of coverage from their employer and even if the dependent coverage offered by the employer is unaffordable, all dependents are considered to have MEC. While CMS regulations provide dependents in this situation with an exemption from the individual responsibility penalty, the children still need health insurance. Without CHIP financing to support All Kids, households who face this "family glitch" are unlikely to have an affordable coverage option for their children.

Two recent articles appearing in *Health Affairs* that document the hit to children's coverage that would be experienced from ending CHIP support our analysis. Abdus [1] et al. used a carefully developed simulation model to estimate the impact on children's coverage of these kinds of changes (i.e. from CHIP to Marketplace) and found it would materially reduce coverage. McMorrow [2] et al. suggested that more than 50 percent of children currently on CHIP would not be eligible for the Marketplace because of parental access to other MEC. If insurance were purchased from this other source, it would materially increase premiums and other costs, resulting in the loss of coverage estimated by Abdus et al.

4. *Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?*

We strongly recommend extending CHIP funding for five years. Because of the significantly lower amount of subsidy for Marketplace plans and the lack of any public subsidy for employer sponsored plans, we believe a significant number of families would choose to forgo health coverage for their children should CHIP funded All Kids coverage be eliminated.

5. *In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?*

The allotments have been sufficient for Illinois since 2009. At this time, we do not see a need to adjust the process for reallocating unspent funds. However, we strongly encourage the Congress to preserve the 23 percent increase in CHIP federal financial participation (FFP) scheduled for 2016 and also assure that state allotments are adequate to permit us to take full advantage of the increase in FFP.

6. *Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?*

Illinois strongly recommends allowing states to use CHIP funds to cover undocumented children through age 18. Regardless of how they came to live in the United States, an investment in children is an investment in the future. For this reason,

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[1] Abdus, S. et al., "Children's Health Insurance Program Premiums Adversely Affect Enrollment Especially among Lower-income Children," Health Affairs (Vol. 33, Num. 8; August, 2014), pp. 1353–1360.

[2] McMorrow, S. et al., "Trade-Offs Between Public and Private Coverage for Low-Income Children Have Implications for Future Policy Debates," op. cit., pp. 1367–1374.

we work to promote the health of all children residing in Illinois and request federal funding to support this goal.

In closing, I must stress that preserving the support CHIP provides to states is critical to assuring we do not lose ground in our quest to give all of our children the health care they need to thrive.

Sincerely,

Pat Quinn, Governor of Illinois

Indiana Family and Social Services Administration

Michael R. Pence, Governor
State of Indiana

Office of Medicaid Policy and Planning

MS 07, 402 W. WASHINGTON STREET, ROOM W382
INDIANAPOLIS, IN 46204–2739

December 12, 2014

The Honorable Ron Wyden
Chairman
Senate Finance Committee

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee

The Honorable Fred Upton
Chairman
Energy and Commerce Committee

The Honorable Henry A. Waxman
Ranking Member
Energy and Commerce Committee

Dear Chairman Wyden, Ranking Member Hatch, Chairman Upton, and Ranking Member Waxman:

Indiana appreciates the opportunity to respond to your questions about the Children's Health Insurance Program (CHIP) and health coverage for children in our state. We applaud efforts by Congress to ensure low income children have access to affordable, high quality health care coverage and recognize the significant contribution of CHIP in accomplishing this goal. In determining the appropriate course for the CHIP program in both the short term and the long term, we recommend that Congress address several challenges to children's coverage put in place by the Patient Protection and Affordable Care Act (PPACA).

Many families struggle to afford health care coverage in our state because of increased costs directly related to PPAC's changes to insurer ratings rules. We estimate that these changes have resulted in cost increases of 50 to 100 percent, which puts a substantial strain on family budgets. In addition, the advance premium tax credits available to adults through the Market place do not coordinate with the CHIP program and separate children from their parent's health plans. Children may receive coverage through the CHIP program or Medicaid and their parents may receive coverage through the Marketplaces, which means that many families must manage multiple health programs.

In addition, PPACA could create a perverse incentive for employers to increase the cost of dependent coverage. The law requires an employer to offer coverage that costs no more than 9.5 percent of income for the eligible employee; however, if coverage for the employee is considered "affordable" then, regardless of the cost of family coverage, all family members are disqualified from accessing the PPACA's tax credits to purchase private family policies on the Marketplace. As long as the cost of the employee's coverage meets the affordability test, the employer avoids a penalty. This so-called "family glitch" therefore has the potential to thwart access to subsidies designed to increase access to health insurance.

Congress should repeal PPACA and enact legislation that offers families more choices to enroll their children into private market coverage instead of being forced into government health care programs. Subsidies should create affordable health care options and be coordinated across programs so that families have the choice

of obtaining a private health plan that covers the entire family through the Marketplace or an employer plan, if that plan meets their needs.

If Congress continues CHIP, the program should be targeted to the lowest income children, reflecting the bipartisan compromise approved by Congress in 1997 that provided coverage for the neediest children without expanding government programs into the middle class. A continued CHIP must provide states with maximum flexibility to achieve coordination of family coverage without federal requirements that limit family choices and access to private market plans. Legislation should be structured to allow states to integrate CHIP with existing Medicaid reform models, such as our state's Healthy Indiana Plan (HIP). The HIP program prepares individuals to move from public assistance to the private insurance market and advances consumer-driven health care while creating incentives for participants to obtain preventive care and adopt healthy lifestyles.

Below, we provide responses to each of your specific questions.

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

In October 2014, 74,518 individuals were enrolled in the Indiana CHIP program. This includes both the Medicaid Expansion Program (MCHIP) and the Separate CHIP (SCHIP) populations.

Program	Number Enrolled October 2013	Number Enrolled October 2014
Medicaid Expansion CHIP (MCHIP) Age 0–1:157%–208% FPL * Ages 1–5: 141%–158% FPL * Ages 6–18: 106%–158% FPL *	54,285	50,675
Separate CHIP (SCHIP) Age 0–1: >208%–250% * Ages 1–18: >158%–250% *	26,734	23,843
Total	81,019	74,518

* All FPL percentages represent MAGI rates effective Jan 1, 2014

The demographic analysis of the CHIP population found here applies to the 2013 program enrollees. Nearly half of the children enrolled in CHIP are between the ages of 6 and 12. This is because children under age 6 are eligible for Medicaid at higher family income levels. Just fewer than 35 percent of CHIP enrollees are teenagers, while the remaining 17 percent are under age 6. This distribution is consistent with observed demographics since CHIP was first implemented in Indiana.

There is a higher distribution of minorities in Indiana's CHIP program than the overall population in Indiana for children ages 18 and younger. Compared to the U.S. Census estimate, African-American children (15.9% of CHIP enrollees in CY 2013) and Hispanic children (14.3% of CHIP enrollees in CY 2013) are represented more in CHIP than in the statewide population. Between CY 2011 and CY 2013, the proportion of Caucasian CHIP members declined (67.5 and 65.5, respectively). The African-American proportion increased from 14.4 percent in 2011 to 15.9 percent in 2013. The Hispanic proportion decreased slightly from 14.8 percent in 2011 to 14.3 percent in 2013. Other races have increased from 3.3 percent in 2011 to 4.3 percent in 2013.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

Indiana operates its CHIP program in close coordination with the Medicaid program. The changes made to the CHIP program for PPACA mirror the overall Medicaid program changes that were required by the PPACA. Indiana has had a single, streamlined application and eligibility process for both Medicaid and CHIP for many years. This allowed us to make only a few changes to the CHIP program and stay compliant with new Federal rules. The following highlight the major changes:

- The Indiana Health Coverage Programs Application was altered to meet new PPACA requirements. This application is for all Medicaid and CHIP program eligibility.
- The financial eligibility guidelines were modified to reflect the Modified Adjusted Gross Income (MAGI) methodology. New MAGI adjusted FPLs for allcategories led to an adjustment of the lowest level FPL for the SCHIP income eligibility standard.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

The Indiana SCHIP program requires monthly premiums and a limited set of co-pays. Monthly premiums are set on a sliding scale based on family income and the number of children covered. The table below details premium charges. Co-pays are assessed for prescription drugs ($3 or $10 per prescription) and for emergency ambulance transportation ($10).

Number of Covered Children	Up to 175% FPL	Up to 200% FPL	Up to 225% FPL	Up to 250% FPL
1	$22	$33	$42	$53
2 or more	$33	$50	$53	$70

Children in the MCHIP program are covered by full State Plan benefits. Children in the SCHIP program have access to slightly fewer services, including no organ transplants, no non-emergency transportation, and limitations to physical, speech, and occupational therapy.

The Medicaid State Plan provides services beyond the standard commercial plan and Essential Health Benefits. We do not have a detailed comparison of SCHIP cost sharing and coverage compared to typical exchange products or commercial cost sharing and coverage.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able toobtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

Indiana supports efforts to ensure that children have access to affordable health care coverage and we encourage Congress to seek solutions to the issues outlined above. Congress should also be mindful of the cost of these efforts, as states are already burdened by the PPACA's many unfunded mandates. We also recommend timely action to avoid any coverage gaps for children.

Extension of CHIP funding should be considered in the context of addressing the current barriers to family coverage created by PPACA. Again, we believe there is significant value in families taking advantage of family coverage options in the private market and we encourage those options over government programs.

Indiana is currently exploring premium assistance options to keep parents and their children together using CHIP dollars. If CHIP funding is extended, we believe the federal government should make it easier for states to coordinate their CHIP programs with the Marketplace and employer plans and eliminate problems resulting from health coverage silos created in the Affordable Care Act. Indiana also requests that the Maintenance of Effort provision be lifted to allow states the flexibility to establish eligibility levels most appropriate for their states.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

The structure of the CHIP program provides key evidence that states can successfully manage entitlement programs within a block grant structure. Indiana has never exceeded the state's allotment for the CHIP program. The funding formula has never disadvantaged Indiana or limited our ability to cover the populations we

believe are most in need of assistance. However, we believe states should have even more flexibility with the use of CHIP dollars—for example, in the areas of benefit and cost-sharing design. We believe a block grant funding model with additional flexibility could allow states to develop more innovative Medicaid solutions like the Healthy Indiana Plan that prepare individuals to transition off of public assistance. We encourage Congress to look at this model for structural Medicaid funding reform.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

The current policies of the CHIP program have positively impacted the health of children in our state and have allowed us to have one of the lowest uninsured rates for children under 200% FPL. For this income group, Indiana's most recent uninsured rate is 10.3 percent compared to the national average of 14.4 percent. Indiana's 10.3 percent uninsured rate among children in families below 200 percent of the FPL places the State as the 15th lowest uninsured rate in the country for this income group among all states.

In conclusion, we strongly support efforts to provide health coverage to America's children and recognize, in particular, the role the CHIP program has in addressing the needs of low income children. We believe that policies intended to grow the state's economy will reduce reliance on the CHIP program and move families off public assistance programs and into private coverage. We encourage Congress to work with states to assess alternative private coverage sources in the new coverage landscape lo determine the need for, and design of, the CHIP program moving forward. If the program is continued by Congress, we believe additional flexibility should be given to states in the administration of the program and that assistance in the program should be targeted to the lowest income children reflecting the bipartisan compromise approved by Congress in 1997 that provided coverage for the neediest children without expanding government programs into the middle class. We look forward to working with you on this important effort.

Sincerely,

Joseph Moser
Medicaid Director

Iowa Department of Human Services

1305 E. Walnut Street, Des Moines, IA 50319–0114

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

The Honorable Fred Upton
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The Honorable Henry A. Waxman
Ranking Member
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The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
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The Honorable Orrin G. Hatch
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Upton, Ranking Member Waxman, Chairman Wyden, Ranking Member Hatch:

The purpose of this letter is to respond to specific questions regarding the reauthorization of the Children's Health Insurance Program (CHIP), for which funding expires at the end of Federal Fiscal Year 2015.

CHIP is a successful program providing affordable access to healthcare coverage for children of the working poor. In considering CHIP reauthorization, it is necessary to contemplate the current context of healthcare coverage post implementation of the Patient Protection and Affordable Care Act (PPACA). Viewed through this lens, the value of CHIP can be less clear as new options for healthcare coverage have emerged in a complicated patchwork of eligibility boundaries, coverage mechanisms and subsidy levels. This has produced confusion for families as different individual qualifications cause them to fracture across multiple plans, each with unique coverage policies and provider networks. The result is an overall approach to healthcare support layered with disorder and inefficiency.

Iowa believes it is necessary to streamline and simplify eligibility moving forward with a goal of keeping families together, as is generally the case under private coverage. It is understood that will take time. In the near term, CHIP funding should be extended for two more years while that simplified course is charted. We must ensure the stability of this coverage group, especially when considering the implications for states regarding maintenance of effort requirements found in PPACA.

Included are responses to the July 29, 2014, letter from congress regarding Iowa's CHIP program. Please feel free to contact me if you need additional information.

Sincerely,

Charles M. Palmer
Director

CMP/jl

Attachment

cc: IME, Julie Lovelady, Medicaid Director
IME, Bob Schlueter, CHIP Director
Mr. Doug Hoelscher, Office of State-Federal Relations

July 29, 2014 Letter from Congress CHIP Q&A

- **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g., income, health status, demographics)?**

  Response: Iowa's CHIP program is made up of three components: a Medicaid expansion component, a separate CHIP component (***hawk-i***), and a dental-only component (***hawk-i*** dental-only). As of April 2014, the number of children served by the Medicaid expansion component was 26,781 children, the separate CHIP component (***hawk-i***) was 36,904 children, and the dental-only component (***hawk-i*** dental-only) was 3,504 children. Combining all groups brings the total to 67,189.

  Within the ***hawk-i*** program, approximately 70% are at or below 200% of the federal poverty level. The racial and ethnic breakdown of these individuals is approximately 47% White, 5% Hispanic, 1.9% Black, 1% Asian/Pacific Islander, and 44% unspecified.

- **What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?**

  Response: The biggest change was the conversion to the PPACA's MAGI method of income determination on January 1, 2014. That implementation has not fundamentally changed the population served. The administration of the program also remains consistent with pre PPACA approach, although technical details around implementing MAGI (including the new eligibility system related to that) have presented a number of detail operational changes.

- **To the extent of the following information is readily available and you believe it is relevant, please describe the services and or benefits and or**

cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Response: The benefits of the CHIP ***hawk-i*** component would be roughly comparable to Qualified Health Plan (QHP) coverage on the federal Marketplace, but the cost sharing would be lower in virtually all cases. Benefits under the Medicaid expansion component would be superior to the QHP and also include Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. EPSDT is the child health component of Medicaid and basically mandates extensive coverage of anything diagnosed in a child; this means things like glasses would be covered under CHIP that may not be typical of marketplace or employer-based coverage. Iowa's CHIP does not have cost sharing for any of its benefits and service, but can include premiums up to $40.

- **Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?**

  Response: We recommend that CHIP financing be extended at least two years until alternative policy options can be fully considered. One alternative for CHIP enrollees is subsidized coverage available through the Marketplace. Certain policy changes will need to take place before states can move freely in this direction.

  Currently, Department of Treasury rules do not allow the children of an employee to access federal Premium Tax Credits if the employee is offered affordable employer-sponsored insurance. However, the affordability test does not take into consideration the cost of family coverage, only individual coverage. Without a change in this policy, families that are subject to this standard would be unable to attain affordable coverage for their children. If comparable, affordable QHP coverage is available for families in the Marketplace, it could be considered as an option for uninsured children if CHIP were not continued.

  In addition, the Maintenance of Effort (MOE) requirements in the PPACA need to be modified to reflect any changes to the program. As long as the MOE requirement remains part of federal law, we cannot consider changes that affect CHIP. After these changes are made, states will be able to further consider policy options regarding the CHIP program.

- **In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?**

  Response: Federal Fiscal Year (FFY)13 and FFY14 allotments have been adequate to fund Iowa's CHIP program. It is unclear if there will be sufficient funding in FFY15 and beyond, to maintain Iowa's CHIP program. PPACA directs that beginning October 1, 2015 the already enhanced CHIP federal matching rate will increase by 23 percentage points, bringing the average federal matching rate for CHIP to 93%. The enhanced federal matching rate continues until September 30, 2019. This legislation would require a much larger annual allotment in order for Iowa to maintain the CHIP program in its current form.

- **Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?**

  Response: Federal policies should streamline and simplify eligibility policies of the various programs. CHIP, Medicaid and the Health Insurance Marketplace have been layered, creating both unnecessary redundancy and coverage silos. The resulting "system" is complex, creates confusion and exacerbates churn as beneficiaries move across various boundaries around age, income and other qualifications. It is often impossible to keep families together in a unified coverage. Poli-

cies that help the parents of children gain coverage and stay enrolled would help to improve the penetration rate and reduce the uninsured rate.

Once coverage is clear and secure, healthcare system transformation efforts, such as ACO, show a great deal of promise in improving health outcomes for both children and adults. In addition, partnerships with groups outside of the ACO, such as public health or outreach workers, could help to mitigate some of the gaps that prevent individuals and families from engaging in more healthy behaviors. Within Iowa's SIM test, the multi-payer aligned healthcare transformation process is intended to expand across greater segments of the population, including CHIP. This payment structure and related reforms is pushing for improved population health outcomes by focusing payment on value.

Kansas

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Robert Moser, MD, Secretary — Sam Brownback, Governor

Dear Chairmen and Ranking Members:

Thank you for your inquiry regarding the Children's Health Insurance Program (CHIP). I agree that it is crucial that Members of Congress seek insight and analysis on federal/state partnerships such as CHIP. I have considered each of your questions and provided the pertinent information and recommendations. I have included each of the questions from your initial correspondence for reference.

1. *How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?*

Concerning enrollment, 56,705 children were covered by CHIP as of June, 2014. Age groupings are less than 1% under age 1; 18.5% for ages 1–5; 47.4% for ages between 6 and 12; and 33.4% for teenagers.

Concerning demographics, 67.3% reside in an urban setting, 28.4% reside in a rural county and 4.3% live in a frontier community. 51.3% were male and 48.7% were females.

Concerning income characteristics, 53.3% belong to households with incomes less than 150% FPL, 34.3% belong to households with incomes between 150 and 200% FPL and 12.4% belong to households with incomes over 200% FPL.

Looking at Health Status information, claims/type of services rendered during FY 2013 and 2014, most services are associated with normal childhood illnesses (ear infections, flu, eye problems, other infections and childhood injuries). The large number of mental health services is also worth noting. Children meeting disability criteria are generally covered under Medicaid categories and are not covered by the CHIP program.

2. *What changes has your state made to its CHIP program as a result of the ACA? How has implementation of the ACA impacted the way your state administers CHIP?*

Kansas has always operated an integrated Medicaid/CHIP program, so changes to CHIP have not been significant.

Kansas has implemented:

a. The new MAGI methodologies requiring the use of new household and income requirements.
b. The new "m-chip" group (moving a group of children from CHIP into Medicaid) is mandated by the ACA.
c. The new Premium payment enforcement timeline—under previous policy, families who were delinquent on premium payments were not eligible until

they became current on payments. We are now applying 3 months maximum non-payment penalty as mandated by the ACA and/or associated regulations.

d. Changes in the crowd-out. Crowd out occurs when someone voluntarily drops health insurance in order to be eligible for CHIP. Previously, Kansas had an 8 month waiting period from the date of voluntarily dropping coverage. As required by ACA, Kansas changed the look-back timeframe from 8 months to 3 months.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and/or benefits and/or cost sharing that is currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer-sponsored health plans in your state.

That information is as follows:

a. Cost sharing: The only cost sharing for CHIP in Kansas are premiums (see chart below) for some higher income families. There are no deductibles or co-pays. Here are the levels of premium obligations:

FPL Percentage	Premium Amount
167–191%	$20
192–218%	$30
219–242%	$50

b. Benefits: As indicated under Question 2, Kansas operates an integrated Medicaid/CHIP program. The benefit coverage is the same between programs including the Early Periodic Screening Diagnosis and Treatment provision. No commercial insurance has a benefit coverage as rich as the Medicaid/CHIP coverage.

4. Do you recommend that CHIP funding be extended? If so for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon any extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

Yes, a 5 year extension to CHIP funding should be considered for budgeting and planning purposes. In the absence of CHIP, the only other options would be employer-sponsored coverage or coverage through the Exchange. Either option would have a less rich benefit package and higher cost sharing. It can be assumed that most of the non-premium paying children may become uninsured if CHIP is not extended.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

The annual allotment for Kansas has been sufficient. Additionally, the State of Kansas has not lapsed on any CHIP funding allotments.

6. Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component to that effort. Do you believe there arefederal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?

Give States more flexibility in program design allowing the States to design program models specific to their population mix and budget constraints.

Relax Waiver red tape and encourage agility and flexibility in program development.

Enact federal policy addressing beneficiary overpayments that include the ability to establish penalty periods for individuals who haven't accurately reported information.

Allow options for repayment of overpayment, including the ability for states to utilize federal debt set-off for repayment of medical assistance claims attributed to beneficiary overpayments.

I appreciate the opportunity to answer your questions and provide these recommendations on improving CHIP. If you need additional information or have further questions, please contact me.

Sincerely,

Susan Mosier, MD, MBA, FACS
Division Director and Medicaid Director
Division of Health Care Finance
Kansas Department of Health and Environment

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October 20, 2014

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2183 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
2204 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Upton, Chairman Wyden, Ranking Member Waxman, and Ranking Member Hatch:

I am writing in response to your letter of July 29, 2014, seeking state input on the Children's Health Insurance Program (CHIP).

I am incredibly proud of the work we have done to provide access to affordable health insurance through kynect, the state's health insurance exchange, and the national attention we have received for so dramatically reducing our uninsured rate. However, before we began these efforts through kynect, I worked to greatly lower our rate of uninsured children. I strongly believe that it is shameful and shortsighted to deny children with the health care they need and deserve.

In 2008, I launched a plan through the Kentucky Children's Health Insurance Program (KCHIP) to dramatically cut the number of children without health coverage by removing barriers to enrollment, retaining more children once they are enrolled and significantly increasing education and outreach. The steps we took to get more eligible children enrolled in KCHIP were fiscally responsible, economically smart, and an unqualified success. Since the launch of our efforts, the number of Medicaid-covered children has increased by 97,251, a 22 percent increase, which includes an increase of 10,563 children in KCHIP. In addition, we eliminated a six-month waiting period to enroll in KCHIP that had been required for children whose

private insurance was dropped voluntarily and whose family income was between 150 percent and 200 percent of the federal poverty level. Finally, earlier this year, we removed the five-year ban for lawfully present residents under the age of 18 to enroll in KCHIP.

KCHIP has been essential to ensuring that quality health coverage for Kentucky's children is affordable and accessible. As you know, children with health coverage have improved health outcomes throughout their childhood and are more likely to receive preventive care, treatment when they are ill and for recurring illnesses; get sick less frequently; have better attendance and performance at school; and have parents with better attendance and performance at work. Quite simply, KCHIP is a vital piece of the health care landscape for Kentucky's children and I urge its immediate reauthorization.

Below are answers to your specific questions:

1. **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?**

   Currently, 21,159 children are enrolled in the Medicaid Expansion portion of CHIP and 25,988 children are enrolled in the separate portion program.

   As a result of the new MAGI income calculation methodology, children may be enrolled in KCHIP if household MAGI is at or below 159% of the federal poverty level (FPL), and they may enroll in the separate portion program at income levels up to 218% FPL. The previous thresholds were 150% and 200% respectively.

   Children receiving disability benefits are not generally enrolled in KCHIP, but are eligible through programs for the disabled, though there may be some children with disabilities who do not qualify for disability payments that are enrolled in the program. Generally, both KCHIP and the separate portion program are comprised of children without disabilities.

   The demographics of the combined group are below. These children are 51.08% male and 48.92% female (table 1). More than 97% of the children identify as non-Hispanic (table 2). Almost 60% do not list a standard federal racial category at the time of application, while 35% identify as white and 4.6% identify as black (Table 3). The enrollment by age group is shown in table 4.

Table 1. KCHIP Enrollment by Gender

Gender	Percent
F	48.92%
M	51.08%

Table 2. KCHIP Enrollment by Ethnicity

Ethnicity	Percent
Hispanic	2.23%
Non-Hispanic	97.73%
Not Listed	0.04%

Table 3. KCHIP Enrollment by Race

Race	Percent
E—Other Race or Ethnicity	59.45%
0—White	35.10%
B—Black	4.62%
A—Asian or Pacific Islander	0.50%
7—Not Provided	0.04%
I—American Indian or Alaskan Native	0.18%
J—Native Hawaiian	0.11%

Table 4. KCHIP Enrollment by Age Group

Age Group	Percent
0–5	20.95%
6–12	43.54%
13–18	35.51%

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

As I mentioned above, Kentucky lifted the five-year waiting period for lawfully residing immigrant children. We have also added a substance use treatment benefit as a Medicaid covered service and amended cost-sharing requirements for children. Kentucky utilizes the existing Medicaid infrastructure to administer KCHIP; therefore, implementation of PPACA had a minimal impact on KCHIP, outside of the small impact of the MAGI calculation methodology on income thresholds.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Kynect adopted the KCHIP vision and dental benefit package, which makes the two benefit packages more comparable. However, cost sharing in KCHIP is limited. Kentucky does not have a monthly premium or enrollment fee for KCHIP, while the monthly premiums, co-payments, deductibles, and cost-sharing in kynect are higher for families with children, depending on the income of the family.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

CHIP funding must be extended until all Kentucky families' income no longer necessitates the need for this assistance. It is short-sighted to deny children health care coverage—sick children cannot be successful students; sick children cannot thrive in our workforce; and sick children will not lead the happy, productive lives that they deserve. I cannot urge strongly enough for you to continue funding for CHIP.

If a decision is made NOT to fund CHIP after FY2015, as many as 50,000 Kentucky children will lose health care coverage.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

The restructuring and retargeting of allotments in 2009 have been adequate and sufficient for Kentucky; so far, Kentucky fully expends its annual CHIP allocation. Congress could easily address the issue of unspent allotments by reducing a state's next scheduled allotment by the unspent amount. The state would retain the unspent allotment from the previous period along with the modified new allocation, which would ensure the state retains the allotment necessary to maintain its CHIP program for the new period.

6. Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of

eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

KCHIP and PPACA have been instrumental in reducing the number of uninsured in Kentucky. As mentioned in the answer to question 4, CHIP serves as a vital transition point for children who may eventually move to a qualified health plan through kynect. *Therefore, Kentucky recommends that the federal government fix the "family glitch" that exists in PPACA today.* Since the affordability test for individuals who have access to other insurance is based on the cost of a single plan and not the cost of a family plan, the only options currently available to families who cannot afford the cost of a family plan through their employer are either enrolling in CHIP or not insuring their entire family. This unfortunate glitch must be addressed.

I greatly appreciate the opportunity to provide my perspective on this critical program. Continued funding of this program is the right thing to do and Congress should view it as a moral obligation.

Sincerely,

Steven L. Beshear

State of Maryland

Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor—Anthony G. Brown, Lt. Governor—Joshua M. Sharfstein, M.D., Secretary

September 4, 2014

The Honorable Ron Wyden
Chairman
Senate Finance Committee
219 Dirksen Senate Office Bldg.
Washington, DC 20510

The Honorable Fred Upton
Chairman
House Energy and Commerce Committee
2125 Rayburn House Office Bldg.
Washington, DC 20515

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Bldg.
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The Honorable Henry A. Waxman
Ranking Member
House Energy and Commerce Committee
2322A Rayburn House Office Bldg.
Washington, DC 20515

Dear Chairman Wyden, Senator Hatch, Chairman Upton and Congressman Waxman:

Thank you for your letter to Governor O'Malley regarding funding for the Children's Health Insurance Program (CHIP) and to inquire about program data and policy changes as the program moves forward. The Governor received your letter and asked me to respond on his behalf.

Maryland operates a Medicaid expansion CHIP program called the Maryland Children's Health Program (MCHP). MCHP provides full health benefits for children up to age 19 who have household incomes below 300 percent of the federal poverty level (FPL) ($71,550 for a family of four); families between 200 percent and 300 percent FPL are required to pay a monthly premium. Benefits are obtained through the managed care organizations that participate in HealthChoice, Maryland's Medicaid managed care program. Benefits include, but are not limited to: doctor visits (well and sick care); hospitalization; lab work and tests; dental care; vision exams and corrective lenses; hearing exams and hearing aids; immunizations; prescription drugs; transportation to medical appointments; mental health services; inpatient and outpatient behavioral health services; physical and occupational therapy; services for speech, hearing and language disorders; and durable medical equipment.

Congress has not authorized funds for the CHIP program beyond Federal Fiscal Year (FFY) 2015. We strongly urge Congress to reauthorize the program and to make changes to the allotment formula to account for the enhanced FMAP slated to begin October 1, 2015. The Patient Protection and Affordable Care Act (PPACA)

includes a provision for a 23 percentage point increase in Maryland's CHIP Federal Medical Assistance Percentage (FMAP) match rate effective October 1, 2015 (FFY 2016), which will enhance Maryland's FMAP from 65 percent to 88 percent. As a result, any funds carried over from the FFY 2015 authorization will be exhausted more quickly than in previous fiscal years. Without additional CHIP funding, once FFY 2015 funds are depleted, MCHP expenses will be subject to the regular Medicaid FMAP of 50 percent. With enrollment in MCHP and MCHP Premium likely to continue to increase due to PPACCA, this State fiscal impact has the potential to be even more significant.

Below are answers to the specific questions you posed in your letter:

l. *How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g., income, health status, demographics)?*

As of July 2014, 97,158 children are enrolled in MCHP. A total of 18,262 children in MCHP are enrolled in MCHP Premium.

2. *What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?*

PPACA has had a modest impact on the way Maryland administers MCHP. MCHP eligibility determinations are now based on the applicant's modified adjusted gross income (MAGI), rather than the income disregard and asset rules used in the past. Maryland has not seen a decrease in enrollment due to this new eligibility determination method. PPACA has also opened up new avenues for Maryland families to apply for MCHP. Families can now apply for coverage by completing an application using Maryland's Marketplace, the Maryland Health Connection, by contacting the Maryland Health Connection Consumer Support Center, or by visiting a Connector Entity. Individuals also continue to be able to apply at Local Health Departments, Local Departments of Social Services, online using the Maryland SAIL application, and by mail.

3. *To the extent the following information is readily available and you believe it is relevant, please describe the services and/or benefits and/or cost-sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer-sponsored health plans in your state.*

Individuals enrolled in MCHP are exempt from cost-sharing requirements for all services and prescription costs. MCHP recipients also receive the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children enrolled in the program. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health and developmental, and specialty services.

4. *Do you recommend that CHIP funding be extended? lf so, for how long, And for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?*

Maryland strongly recommends that CHIP funding be extended. The State anticipates additional funding will be required in FFY 2016. However, for budgeting and planning purposes, an extension would ideally be granted prior to the commencement of the State Fiscal Year 2016 on July 1, 2015.

5. *In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?*

Through FFY 2013, Maryland has been sufficiently funded for its CHIP expenditures, through a combination of "rollover" unused allotment from its prior Federal Fiscal Years(s) and the fresh allotments for each of its "current" Federal Fiscal Year(s). From most recent FFY 2014 actuals and projections, we expect to have ample allotment funding through FFY 2014, and we are reasonably comfortable with FFY 2015 projections.

However, we are keeping a close watch on recent increased expenditure trends due to CHIP enrollment growth (at least in part due to the impact of PPACA), and increased participation in CHIP administrative match due to additional claims from Maryland agencies that perform CHIP-related eligibility and other administrative functions: the Maryland Department of Human Resources (DHR), the Maryland Health Benefit Exchange (MHBE), and the University of Maryland School of Pharmacy Poison Control Center. This, in conjunction with the provision for a 23 percentage point increase in Maryland's CHIP FMAP match rate effective October 1, 2015 (FFY 2016), leaves us with a concern for how expanded allotment needs will be addressed in FFY 2016 and beyond. Maryland anticipates that the higher CHIP FMAP will result in available federal funding being depleted more quickly than in previous FFYs.

6. *Over the years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state!*

- In FFY 2009 under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Congress appropriated funding for annual CHIP performance bonuses for states that were able to (1) increase child enrollment in Medicaid (not CHIP) by a certain amount and (2) implement at least five out of eight specific outreach and retention strategies that make it less difficult to enroll and retain eligible children in Medicaid and CHIP. Maryland was able to meet these requirements and to date, has received nearly $86.5 million in bonus payments. This federal payment is needed to help states maintain the increased enrollment levels that were achieved by meeting the standards that Congress established. Congress should continue to make these bonus payments available to states as part of any CHIP funding renewal legislation.
- Under CHIPRA, states are authorized to use eligibility information from other programs to streamline and simplify enrollment and renewals in Medicaid and CHIP. This process is known as Express Lane Eligibility. Express Lane Eligibility permits states to rely on findings, for things like income and household size, from certain designated programs. This enables states to avoid duplicative enrollment efforts and lowers administrative costs as a result. Congress should renew the Express Lane Eligibility provision.
- In FFY 2016, the FMAP for CHIP will increase by 23 percentage points, so that Maryland's FMAP will increase from 65 percent to 88 percent. The practical effect of this increase is that Maryland will exhaust its federal allotment for MCHP more quickly. Congress should maintain the enhanced FMAP increase and adjust the allotment formula accordingly so that state CHIP programs have a stable, predictable funding source.
- Under current law, children enrolled in Medicaid-expansion CHIP programs (like Maryland's) are enrolled in Medicaid but funded by CHIP. The PPACA includes a maintenance of effort (MOE) requirement that states maintain their Medicaid and CHIP eligibility levels for children until September 30, 2019. When a state's CHIP funding is exhausted, these children will continue to be enrolled in Medicaid but will be funded at the state's regular Medicaid match rate instead of CHIP's enhanced FMAP levels, which will require significantly higher levels of state funding.

Thank you again for your inquiry. We look forward to working with our partners at the federal level to maintain this valuable resource for care that so many of Maryland's children have come to rely on. If you have questions or need more information on Maryland's CHIP program, please do not hesitate to contact Tricia Roddy, Director of Planning, Office of Health Care Financing.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

cc: The Honorable Martin O'Malley
Tricia Roddy

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DEVAL L. PATRICK
GOVERNOR

October 30, 2014

The Honorable Ron Wyden
Chairman, Senate Finance Committee

The Honorable Orrin G. Hatch
Ranking Member, Senate Finance Committee

The Honorable Fred Upton
Chairman, House Energy and Commerce Committee

The Honorable Henry A. Waxman
Ranking Member, House Energy and Commerce Committee

Dear Senator Wyden, Senator Hatch, Representative Upton and Representative Waxman:

I am pleased to provide response to your letter of July 29, 2014, regarding the operation of the Children's Health Insurance Program (CHIP) in Massachusetts.

Massachusetts has achieved near-universal coverage thanks in part to programs such as CHIP. Providing coverage reflects our values as a Commonwealth and helps keep families strong and children healthy. Massachusetts is a strong supporter of CHIP and below you will find responses to the specific questions in your July 29, 2014 letter.

1. *How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?*

   As of June 2014, there were 117,000 children enrolled in our CHIP program, including over 1,200 children with disabilities. Just over 95,000 have family income that is less than or equal to 200% of the Federal Poverty level. Of the children for whom we have race information, less than 1% are American Indian/Alaska Native, 2% are interracial, 9% are Asian/Pacific Islander, 14% are Black/Non-Hispanic, 25% are Hispanic and 50% are White.

2. *What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?*

   Massachusetts has updated our CHIP policies to align with PPACA, including the use of Modified Adjusted Gross Income to determine eligibility and altered the residency and citizenship/non-citizen rules related to eligibility. We also updated the rules for children with unpaid premiums to allow the children to re-enroll in CHIP after a 90 day waiting period, even if the premiums remain unpaid.

   The Commonwealth has also extended the hospital presumptive eligibility available under PPACA to individuals eligible under the CHIP unborn child option.

   While this was not required under PPACA, Massachusetts eliminated the six month waiting period that was in place for CHIP children with income 200% to 300% FPL who were ineligible due to having dropped group health insurance coverage.

   Along with the other coverage and eligibility changes made under PPACA, Massachusetts replaced Healthy Start, our CHIP unborn child option program,

which provided only pregnancy related services to pregnant women who were ineligible for the Medicaid (MassHealth) Standard program. These women are now provided with full MassHealth Standard benefits under CHIP.

3. *To the extent the following information is readily available and you believe it is relevant, please describe the services or benefits and/or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored plans in your state.*

Massachusetts charges premiums to CHIP children on a sliding scale (ranging from $12 to $28 per child per month) and caps family premiums at $84 per month, with the result that CHIP premiums are much lower than those charged by private plans. CHIP children are also exempted from paying premiums if they have a parent enrolled in a Qualified Health Plan and receiving tax credits. There is no cost sharing for any services for CHIP children with direct coverage where private plans typically have deductibles and charge copays for most services.

Also, our CHIP plan allows us to provide premium assistance to enable families to enroll their children in available employer-sponsored insurance that they would not otherwise be able to afford. This is not an option available to families in the exchange. Further, combined premiums and cost-sharing in our CHIP premium assistance program cannot exceed 5% of family income making this CHIP program too, like CHIP direct coverage, far more affordable than coverage through an exchange or unsubsidized employer coverage.

In addition, there are some benefits available to children in our CHIP program that are generally not available through private plans, including those offered through the exchange or employer sponsored plans. The scope of benefits in our CHIP program was designed specifically to meet the needs of children. These benefits include eyeglasses, hearing instrument specialist services, diversionary behavioral health services, early intervention services, special education evaluation services, and child-specific screening and diagnostic services. Some of these services are of course available in private plans, but many may not be, particularly in the employer plans that are not subject to our state insurance laws. Our CHIP program also provides full dental benefits for children and while these benefits may be purchased through the exchange as separate plans, a family purchasing dental benefits and medical benefits receives no higher tax credit than a family purchasing only medical benefits. Since dental coverage is not required to meet the individual mandate, it is likely some parents may forgo dental coverage for their children due to costs.

4. *Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe that CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?*

Massachusetts strongly supports the indefinite extension of CHIP funding as it is an integral part of ensuring that low income children have affordable, comprehensive insurance and provides federal financial support to states to help fund that coverage. While children in the Medicaid expansion portion of our CHIP program would be covered through Medicaid if CHIP funding is not extended, the state would no longer receive CHIP enhanced federal funding for their coverage.

Given the differences in cost sharing between our CHIP program and private insurance plans, it is clear that children currently enrolled in our separate CHIP program would be negatively affected if CHIP funding is not extended. If their families are unable to afford the premiums and copays under private insurance, they may become uninsured. As noted above, they may also need benefits that are not generally provided by private insurance.

In addition, many of these families may be impacted by the eligibility standards under the ACA for individuals who have an offer of private insurance through their employer. These standards only take into account the cost to purchase individual coverage through an employer, rather than the cost to purchase family coverage.

It is difficult to estimate the number of children who would become uninsured if CHIP funding is not extended but, given that over 27,000 of the children currently enrolled in our CHIP program have family income above Medicaid levels, but at or below 200% FPL, it is likely that a significant portion of that population would become uninsured if CHIP funding is not extended.

In addition, as you know, the ACA established Maintenance of Eligibility (MOE) requirements that prohibit states, until 2019, from imposing more restrictive eligibility and enrollment standards for children in Medicaid and CHIP. These mandates were effective as of March 23, 2010. We believe that this demonstrates strong legislative intent to continue CHIP program funding until at least 2019.

5. *In spite of the restructuring and reallocation of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received since 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?*

The annual CHIP allotments that we have received since 2009 have been sufficient.

6. *Over the past number of years, states have worked to reduce the number of uninsured children and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job of enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?*

Massachusetts has taken advantage of the Express Lane option in the 2009 CHIP Reauthorization bill and now uses Supplemental Nutrition Assistance Program (SNAP) information to automatically renew children with income up to 150% FPL. We recommend that any CHIP funding extension include additional administrative simplification policies to help increase the number of eligible children in coverage.

Massachusetts also recommends that the Performance Bonus program included in the 2009 Reauthorization bill also be included in any funding extension. However, we recommend that the program be modified to allow bonuses to go to states with smaller percentages of growth but have the highest level of coverage for children as compared to when the 2009 baseline enrollments were calculated. The current program penalizes states: such as Massachusetts, that have traditionally had high levels of coverage and therefore cannot achieve the significant percentage gains in coverage necessary to qualify for a bonus.

The quality provisions included in the 2009 CHIP Reauthorization, including the establishment of a core set of children's health care quality measures and the CHIPRA Quality Demonstration grants have done much to advance the quality of care provided to children and we hope that any extension of CHIP funding would include a similar emphasis on quality of care. The quality funding in CHIPRA continues to improve the value of CHIP funded coverage and services. The investment has already advanced work on better quality measurement in pediatrics, spread of best practices in Patient Centered Medical Home service delivery, and the creation of a multi-stakeholder coalition to set improvement priorities and collaborative approaches to improvement in pediatric health care.

Finally, Massachusetts has found federal funding to support outreach to be extremely helpful as we try to find and enroll the remaining 1–2% of uninsured children in the state and hope that such funding will continue to be available in the future.

Thank you for your interest in the Commonwealth's CHIP program and for the opportunity for us to share our strong support for reauthorization of the CHIP program and for changes to improve and strengthen this valuable program. Please do not hesitate to contact me for any further information.

Sincerely,

Deval. L. Patrick
Governor

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

Rick Snyder
GOVERNOR

Nick Lyon
DIRECTOR

November 25, 2014

Mr. Fred Upton, Chairman
U.S. House of Representatives
Committee on Energy and Commerce

Mr. Ron Wyden, Chairman
U.S. Senate
Committee on Finance

Mr. Henry A. Waxman, Ranking Member
U.S. House of Representatives
Committee on Energy and Commerce

Mr. Orrin G. Hatch, Ranking Member
U.S. Senate
Committee on Finance

Dear Representatives Upton and Waxman and Senators Wyden and Hatch:

This is in response to your letter of July 29, 2014, requesting information from Michigan regarding the Children's Health Insurance Program (CHIP) and its possible extension. After a brief introduction, this letter will respond to the specific questions laid out in your letter. You will find that our input leads to a strong recommendation that Congress reauthorize this successful program and maintain enhanced federal match rates that encourage this vital coverage for children.

Michigan's CHIP plan combines a standalone program named MIChild and a smaller CHIP funded Medicaid expansion that covers children above the traditional Medicaid income limits. With these combined strategies, Michigan currently covers close to 45,000 children and has provided services to well over 300,000 children since the inception of the program in 1998. Families with children on MIChild are required to contribute a premium of $10 per month, a meaningful but very affordable form of participation in supporting the cost of care.

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

Michigan's CHIP program currently has about 45,000 children enrolled, 36,000 in the standalone MIChild program and 9,000 in a Medicaid expansion. This expansion provides coverage to 16 to 18 year olds with incomes between 110 and 160% for the federal poverty level. Monthly enrollment has seen a modest increase since the implementation of PPACA. Please see the attached chart for a detailed breakout of the MIChild demographics for three recent months.

2. What changes has your state made to its CHIP program as a result of the Patient Protections and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

Michigan's program has not changed in design since the implementation of PPACA. The flexibilities afforded by CHIP prior to the enactment of the PPACA enabled Michigan to use the program's policy and administrative processes as a template in adapting to PPACA. For instance, Michigan was able to focus on coordination between programs by utilizing our existing CHIP online application as a model for a single application for all Medicaid and CHIP programs allowing us to better coordinate results and referrals among the various programs.

3. To what extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Michigan's MIChild is a standalone program based on employer coverage. By definition, it is comparable to large employer and Qualified Health Plan coverage on the Exchange. One key difference with the Exchange is that MIChild assures dental coverage while it has to be separately purchased on the Exchange, an option that may not be consistently exercised by families.

There also are important and substantial differences between MIChild and QHP cost sharing. Given the deductibles and copays that are built into the QHP cost sharing structure, we are very concerned about the impact on families of children

with health conditions, especially those with special health care needs. Per a recently published Wakely Consulting Group analysis, cost sharing obligations for families can accumulate to more than $1,000 per year and be a barrier to seeking services that are needed.

The most dramatic problem will be for children in families where the employed adult has access to affordable health insurance through their employer but where the policy is not affordable for the family and, hence, the children. This "family glitch" clearly creates a barrier for the affected cohort of children because of the great disparity in the cost of covering children in those families and the inability to access subsidies through the Marketplace.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

The CHIP program provides an affordable health care option for families and facilitates children's access to benefits designed with their specific needs in mind. Current information identifies factors that could significantly erode health coverage of children in various ways if CHIP is not extended. Therefore, we strongly recommend that Congress reauthorize CHIP. We believe that CHIP coverage has helped provide valuable coverage and contributed to the health of Michigan's children.

In terms of timeframe, we would prefer action in the next month or two as we are now in the process of formulating our fiscal year 2016 budget. The budget impact of CHIP ending, or making changes in the state's matching rate, would shift significant costs back to Michigan. If CHIP ended other existing programs would need to provide services to a range of vulnerable children.

We recommend a reauthorization of at least five years so that consistent coverage can be provided to our children. CHIP could be changed if there are other Congressional actions that would assure coverage of children beyond the provisions of PPACA. If that were to occur, changes to CHIP could be made concurrently as part of a larger legislative package.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

The formula seems reasonable but should be able to respond more rapidly as conditions change in a state. Michigan currently is working with CMS to obtain needed allotment adjustments due to such changing conditions. We are anticipating a positive resolution.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

With CHIP and Medicaid, Michigan has built a system that has produced one of the lowest rates of uninsured children in the nation, about 5% for most of the recent years. We believe that the flexibilities afforded by CHIP have contributed to our success. While we have no specific recommendations for additional flexibility at this time, we are open to suggestions that contribute to improved health outcomes for children. We stand ready to help if you or your offices need any assistance or input on suggestions around this or other health programs.

Thank you for this opportunity to provide input on this important issue.

Sincerely,

Nick Lyon, Director
Michigan Department of Community Health

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Chart: Michigan's CHIP Demographics

	May-14		June-14		July-14	
	Count	Percent Enrolled	Count	Percent Enrolled	Count	Percent Enrolled
Gender:						
Female	15,478	48.5%	16,559	48.6%	17,548	48.6%
Male	16,426	51.5%	17,478	51.4%	18,547	51.4%
Gender Total	**31,904**	**100%**	**34,037**	**100%**	**36,095**	**100%**
Age (See note below):						
Under age 1	163	0.5%	81	0.2%	58	0.2%
Age 1 through 4	6,455	20.2%	6,979	20.5%	7,708	21.4%
Age 5 through 14	18,246	57.2%	19,453	57.2%	20,438	56.6%
Age 15 through 18	7,040	22.1%	7,524	22.1%	7,891	21.9%
Age Total	**31,904**	**100%**	**34,037**	**100%**	**36,095**	**100%**
Race:						
American Indian or Alaskan	300	0.9%	299	0.9%	299	0.8%
Asian Indian	49	0.2%	72	0.2%	101	0.3%
Black or African American	3,170	9.9%	3,522	10.3%	3,719	10.3%
Chinese	11	0.0%	15	0.0%	18	0.0%
Filipino	5	0.0%	6	0.0%	6	0.0%
Guamanian or Chamorro	0	0.0%	1	0.0%	1	0.0%
Hispanic	1,125	3.5%	1,073	3.2%	1,053	2.9%
Japanese	1	0.0%	2	0.0%	2	0.0%
Korean	6	0.0%	7	0.0%	7	0.0%
Native Hawaiian	7	0.0%	10	0.0%	12	0.0%
Other Race or Multiracial	1,972	6.2%	1,833	5.4%	1,682	4.7%
Pacific Islander	7	0.0%	15	0.0%	16	0.0%
Samoan	2	0.0%	1	0.0%	2	0.0%
Unknown	2,482	7.8%	2,703	7.9%	2,943	8.2%
Unspecified	70	0.2%	71	0.2%	87	0.2%
Vietnamese	3	0.0%	5	0.0%	6	0.0%
White/Caucasian	22,694	71.1%	24,402	71.7%	26,141	72.4%
Race Total	**31,904**	**100%**	**34,037**	**100%**	**36,095**	**100%**
Ethnicity:						
Chicano	5	0.0%	5	0.0%	7	0.0%
Cuban	5	0.0%	10	0.0%	17	0.0%
Hispanic	322	1.0%	541	1.6%	811	2.2%
Mexican	53	0.2%	65	0.2%	107	0.3%
Mexican American	19	0.1%	26	0.1%	34	0.1%
Non-Hispanic	5,676	17.8%	9,017	26.5%	11,936	33.1%
Other	158	0.5%	193	0.6%	280	0.8%
Puerto Rican	6	0.0%	9	0.0%	12	0.0%
Unknown Ethnicity	25,660	80.4%	24,171	71.0%	22,891	63.4%
Ethnicity Total	**31,899**	**100%**	**34,037**	**100%**	**36,095**	**100%**

Note: The income guideline for children under age 1 is 195 to 212% of the Federal Poverty Level (FPL). The income guideline for other children is 160 to 212% of the FPL.

STATE OF MINNESOTA

OFFICE OF GOVERNOR MARK DAYTON
116 Veterans Service Building • 20 West 12th Street • Saint Paul, MN 55155

October 8, 2014

The Honorable Fred Upton
Chairman
House Committee on Energy and Commerce
Room 2183 Rayburn House Office Building
United States House of Representatives
Washington, DC 20515

The Honorable Ron Wyden
Chairman
Senate Finance Committee
Room 221 Dirksern Senate Office Building
United States Senate
Washington, DC 20510

The Honorable Henry A. Waxman
Ranking Member
House Committee on Energy and Commerce
Room 2204 Rayburn House Office Building
United States House of Representatives
Washington, DC 20515

The Honorable Orrin G. Hatch
Ranking Member
Senate Finance Committee
Room 104 Hart Senate Office Building
United States Senate
Washington, DC 20510

Dear Senators and Congressmen:

Thank you for seeking input from governors regarding whether and how the Children's Health Insurance Program (CHIP) should be extended and whether any additional policy changes are needed.

Minnesota's circumstances differ from most states in the use of CHIP funding. To explain those differences, we offer this brief summary of the CHIP Program as it affected Minnesota. When CHIP was enacted in 1997, Minnesota had one of the lowest rates of uninsured children in the nation. In 1995, Minnesota expanded Medicaid coverage for children under age 21 with family income up to 275% of the federal poverty level through a federal waiver. The laws governing CHIP prevented Minnesota from using CHIP funds for children who were already covered under Medicaid at this high level. Because federal law prevents us from using the CHIP matching funds on behalf of children already covered, Minnesota covers relatively few people under the CHIP program.

Minnesota covers two groups with CHIP funds—a small group of infants under age two; and unborn children of mothers who are ineligible for Medicaid.

Over the years, Minnesota has also used other authority in the CHIP law to support special health initiatives; to cover parents via federal waivers and more recently, the state has used its status as an expansion state to receive enhanced federal matching for a subset of Medicaid children. CHIP funds have helped support coverage for children and their families and I recommend that the program continue.

In response to your more specific questions, I offer the following:

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g., income, health status, demographics)?

Minnesota covers the following groups with CHIP funds:

- Infants up to age two in the Medical Assistance (MA) Program with income between 275% and 283% of the federal poverty level; and
- Unborn children of mothers ineligible for Medicaid who have income up to 278% of the federal poverty level.

Minnesota serves approximately 4,100 CHIP enrollees per year. In addition, the CHIP program provides enhanced funding for children enrolled in Medicaid.

2. *What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?*

Minnesota has no changes other than the conversion of the income standards to the required modified adjusted gross income standards. The most significant impact to administration is the state-based Exchange that supports electronic application processing of Medicaid and CHIP eligibility.

3. *To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer-sponsored health plans in your state.*

Minnesota's CHIP benefits and services are modeled after those offered in the Medicaid program. No premiums or cost-sharing apply to children in either the Medicaid or CHIP programs.

4. *Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?*

I recommend the extension of CHIP funding. This would help us continue to support our investment in health care coverage and continue to reduce the rate of uninsurance. As Governor of Minnesota, I do not plan to recommend reducing coverage for children. Extending the CHIP program would help avoid that result.

5. *In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately?*

Do you believe there is a need for Congress to further address the issue of unspent allotments?

In my view, greater flexibility is needed in order for states to spend all available CHIP funding.

6. *Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?*

I recommend lifting or raising the cap on special health initiatives and other forms of child health assistance. Currently, we are limited to 10% of CHIP program expenditures.

In summary, the CHIP program has helped Minnesota maintain its high levels of coverage for children and maintain its high rate of insurance coverage among children, and l hope that support continues. Please do not hesitate to contact me if you have further questions or need additional information.

Sincerely,

Mark Dayton
Governor

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STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
1100 E. William Street, Suite 101
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ROMAINE GILLILAND
Director

LAURIE SQUARTSOFF
Administrator

BRIAN SANDOVAL
Governor

October 28, 2014

Representative Henry Waxman
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Representative Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Sirs:

The Nevada Division of Health Care Financing and Policy (DHCFP), the Nevada Medicaid and Children's Health Insurance Program administrative entity is supportive of Congress extending CHIP and CHIP funding after the end of Federal Fiscal Year 2015. In Nevada the CHIP is a combination program, both a Medicaid expansion program and a separate CHIP. In both CHIP models, Nevada provides the Medicaid benefit plan where coverage emphasize children's unique needs. The DHCFP believes that the Nevada CHIP does provide medical coverage and care to children who otherwise may not get care due to the high cost of premiums, deductibles and co-payments, that are part of commercial insurance plans, even those with subsidies available through the Heath Care Exchange.

1. *How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state?*

   In State Fiscal Year 2014 (July 2013–June 2014) Nevada's CHIP program covered 5,647 children through the Medicaid expansion program and a monthly average of 21,316 children through the Nevada's Separate CHIP program. The CHIP enrollees in the Medicaid expansion program, where the state receives the CHIP federal match percentage, have income levels up to 165% of the Federal Poverty Level for children below age 6 and have incomes up to 138% of the Federal Poverty Level for children age 6 through 18. Historically about 60% of the Nevada Check Up caseload has identified themselves as Hispanic and 87% of the caseload has resided in the urban areas of Nevada and has been served in our managed care delivery model.

2. *What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?*

   The state consolidated the CHIP and Medicaid eligibility process into a single state Division, the Division of Welfare and Supportive Services. Wherever possible we aligned Medicaid and CHIP policies, including the elimination of the six month

crowd out (wait time between loss of private insurance) period for CHIP. The application process was consolidated and electronic applications can be entered through Nevada Health Link, the front face of the Nevada Health Insurance Exchange and Access Nevada the Division of Welfare and Supportive Services multi benefit application beginning November 2015.

3. *Please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.*

Nevada implements the Medicaid benefit plan which emphasizes child wellness services. It also includes behavioral health rehabilitative supports, dental and vision care and long term services and supports such as private duty nursing and attendant care.

The cost for the CHIP program is significantly less than the cost sharing on the exchange. The only cost is a quarterly premium. There are no co-payments, deductibles, or other charges for covered services. Premiums are determined by family size and income. Premiums are charged per family, not per child and are paid quarterly. The premium for a family with income up to 150% of FPL is $25 per quarter with a total annual cost of $100, for a family with income between 150% and 175% of FPL the premium is $50 per quarter with a total annual cost of $200 and for a family with income between 175% and 205% of FPL the premium is $80 per quarter with a total annual cost of $320.

For a child receiving coverage from a plan on the Health Care Exchange, the average premium cost at an income level of 168% of FPL would be $326 a year for medical coverage. Dental coverage would run an additional $18–$25 dollars a month. At this FPL the co-pays, though subsidized, would also be an additional cost. At 205% FPL, the yearly medical premium would be $534 per year. These premiums are per child. Children are charged individually in a family unit up to the third child; at that point any additional children are not charged an additional premium.

If we utilize the exchange premium payment level of $326 a year, an estimated dental monthly premium of $20 and look at the Nevada CHIP population as a whole we would find that the per year per person cost of going from CHIP to the exchange would be $480.50. This includes premiums only and does not include co-pays. The average CHIP household size is 2.5; therefore, the annual impact per CHIP family would be $1,201.00 plus co-pays.

4. *Do you recommend that CHIP funding be extended? If so, for how long and for budgeting and planning purposes under what timeframe should Congress act upon an extension? How many children do you believe would become uninsured in the absence of CHIP?*

Nevada recommends that the Children's Health Insurance Program funding be extended. It is our belief that CHIP facilitates medical care to children in low income families. In comparing Nevada CHIP HEDIS, The National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set, rates to Nevada Medicaid percentiles, the CHIP program exhibits better rates, demonstrating this receipt of medical care. Because of this level of medical care and the success of CHIP programs we feel the CHIP program should become a permanent program for children, continuing to allow states to operate CHIP as a Medicaid expansion or a standalone CHIP. If Congress is concerned about making CHIP permanent, Nevada believes CHIP should remain funded at least until the end of the children's Maintenance of Eligibility period in 2019. This would give the state time to thoughtfully plan for the needs of these children.

Nevada due to the ability to spend CHIP allotments in a future year, currently anticipates funds will be available through June of 2016. It is projected, if CHIP funding is eliminated that in State Fiscal Year 2017 (the first state fiscal year where lack of federal dollars to support CHIP will affect Nevada) the loss of the increased CHIP federal match percentage will cost Nevada up to an estimated (based on an estimated FMAP) additional $10,000,000 to cover the cost of our Medicaid CHIP expansion children.

For those children in Nevada's Separate CHIP, it would cost Nevada approximately (based on an estimated FMAP) $9.8 million in SGF if we expanded Medicaid children's eligibility and covered these children in Medicaid. To date, this possibility has not been part of Nevada's budget discussions.

For those children in Nevada's Separate CHIP program, if the program was eliminated without expanding Medicaid's coverage of children, with only the option to the families to access the more expensive coverage through the exchange, there is a potential these children will lose their medical coverage. Nevada has no method to determine the number of the children who would actually lose medical coverage, but, based on caseload projections, there are expected to be approximately 15,000 children in the Separate CHIP program that would be at risk.

5. *In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?*

The funding formula has been sufficient for Nevada. Nevada appreciates the ability to use unspent funds in a future year. This has allowed Nevada to address the cost swings that are present in smaller programs when a few high cost children can affect the overall program cost.

The availability to carryover unspent funds has also provided Nevada with the guarantee of some funding to cover ongoing costs, possibly needed for wind down or to transition operations when, through Congressional processes, ongoing CHIP funding has not been assured. Historically, states have continued to operate their CHIP programs, enrolling new children into the health care coverage, pending decisions on continued funding of CHIP from Congress. This remains true for the current situation. States are still operating and enrolling children into CHIP, pending information on the continued funding of the program.

6. *Over the past number of years. States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?*

Nevada has experienced a large increase in program enrollment (Medicaid and CHIP) including children this past year. Nevada believes this can be greatly attributed to the insurance mandate and the increased applications received through the Health Insurance Exchange entry point. Balance needs to be maintained between ease of application and policy for enrolling eligible individuals. Any changes that simplify application and enrollment processes must also be supported by the federally required audits of individual's eligibility. When these audits employ stricter processes than the actual enrollment process does, states are at risk of being cited for enrolling individuals who are not eligible.

Nevada believes program enrollment is only part of the process. Polices and processes need to focus on developing the health care workforce. A limited healthcare workforce will impact health care access and outcomes. There also needs to be federal support, systems and the companion funding, for states to implement expanded health care outcome data gathering and measurement that can be benchmarked across systems and states. States greatly appreciate the opportunities the federal government provides to receive grants or increased federal financial participation to support these activities.

Nevada appreciates the opportunity to provide our information and insights regarding the Children's Health Insurance Program. We believe the program has been successful in Nevada. We believe CHIP does provide medical coverage and care to children who otherwise may not get care due to the higher cost of commercial insurance plans, even those with subsidies available through the Health Care Exchange.

Thank you for your interest in the Children's Health Insurance Program. Should you require any additional information or have any other questions lease feel free to contact Elizabeth Aiello, Deputy Administrator.

Respectfully,

Romaine Gilliland
Director, DHHS

Laurie Squartsoff
Administrator

Cc: Honorable Brian Sandoval, Governor, Nevada
Elizabeth Aiello, Deputy Administrator, DHCFP

STATE OF NEW HAMPSHIRE

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Margaret Wood Hassan
GOVERNOR

October 20, 2014

Congressman Fred Upton, Chair
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Congressman Upton:

Thank you for seeking New Hampshire's feedback on the CHIP Medicaid expansion program for children. We strongly support the reauthorization of CHIP until at least 2019 to both allow sufficient time to ensure that health plans have the ability to serve children with special and intensive needs and to allow Congress to make the technical corrections necessary to the Patient Protection and Affordable Care Act to allow families to more easily access Marketplace plans.

In addition, a change in CHIP Medicaid now would unfairly penalize New Hampshire's children and taxpayers for the state's fiscal responsibility. Several years ago, in a change that reduced state and federal costs, New Hampshire moved its CHIP program into Medicaid. Failure to reauthorize would penalize New Hampshire's efficiency by forcing it to pay more for children's health coverage than other states.

Below you will find New Hampshire's specific responses to the questions posed by the Ranking Members of the House Committee on Energy and Commerce and the Senate Finance Committee on the impact the end of Title XXI CHIP funding could mean to low- to moderate-income families. We have also included information about the health status of children in our CHIP population, which we think supports recent analyses by a number of organizations that the Qualified Health Plans (QHPs) on the Marketplace may not meet children's needs, especially our most vulnerable children, those with special health care needs.[1]

1. How many individuals are served by your state's CHIP Program? What are the characteristics of CHIP enrollees in your state (e.g., income, health status, demographics)?

As of June 30, 2014, New Hampshire had 11,029 children in its CHIP population; about 44 percent were adolescents (12–18 years old). NH has a CHIP Medicaid Expansion (meaning that the CHIP population is enrolled via the Medicaid program as opposed to a stand-alone program outside of Medicaid) to serve these children in the 185–300 percent FPL income group. Approximately three-quarters of these children are in the 185–250 percent FPL income group. Previous analyses of children's health insurance in New Hampshire showed that about half the CHIP program population dis-enrolls each year compared to about one-quarter each of the Medicaid and commercial populations.

These previous analyses of children's health insurance in New Hampshire also included health status classification using a relative clinical risk score (3M's Clinical Risk Grouping software), which showed that among those continuously enrolled (for a year) Medicaid children had the highest score (0.591) with the CHIP population somewhat lower (0.549) but still 10 percent higher than commercially insured chil-

[1] The National Alliance to Advance Adolescent Health, Georgetown University Health Policy Institute Center for Children and Families, Wakely Consulting Group, MACPAC and the GAO.

dren (0.494). Despite similar demographics to the commercially insured children, this group had a higher prevalence rate of mental health disorders (22.7 percent versus 14.2 percent) and about twice the prevalence rate of asthma. The last study, released in 2013, found a shift toward a greater level of chronic disease in CHIP children.[2]

This trend is of concern and supports the need for access to a health benefit plan that addresses the acute and chronic health care needs of children. Despite this shift towards greater chronic illnesses, there are positive outcomes for New Hampshire's children enrolled in the CHIP program. On average CHIP funding allows New Hampshire to provide health care coverage to more than 19,000 children during the course of a year. Over the course of a year CHIP funding in New Hampshire assures access to 46,000 physician/clinic visits (including 6.500 for preventive care), 20,000 dental visits, 10,000 mental health visits, 2,500 emergency department visits, and 57,000 prescriptions filled.

As a result of this care:

- The access to and use of primary care practitioners has improved such that New Hampshire's CHIP rates were higher than both Medicaid and the New Hampshire Commercial rates in the 2013 study.
- Well-child visit rates have increased substantially with the children enrolled in CHIP leading the way (83.9 percent) followed by the commercial insurance (79.3 percent) and Medicaid (73.2 percent).
- Children enrolled in the CHIP program saw a significant improvement in the rates for the appropriate testing and treatment for ambulatory sensitive conditions (ASC) that could be treated in a physician's office rather than in the emergency room. (SFY2011 (88.7 percent) vs SFY2009 (80.0 percent)).
- The use of inpatient hospital services for ASC (asthma, dehydration, bacterial pneumonia, urinary tract infections and gastroenteritis), by children enrolled in the CHIP program (1.6 per 1,000 members) are much less than children enrolled in the Medicaid program (3.4 per 1,000 members) and equal to those with commercial insurance.

Without the CHIP Program, New Hampshire would not have seen such improvements. This is why it is vital that before decisions are made to end the CHIP program, in favor of providing a health benefit through the Marketplace, an analysis of impact on health outcomes must be undertaken. To not look at this question is inviting a cascade of negative, harmful, unintended outcomes for children.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

New Hampshire has applied the new Modified Adjusted Gross Income or MAGI regulations as required by the PPACA to its CHIP program. The key differences between MAGI and the former method for calculating income is the use of a standard 5 percent income disregard and no asset test.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

New Hampshire is a CHIP Medicaid Expansion state; children in the CHIP population receive the Medicaid benefit package, which is a broader set of benefits important to children and adolescents and can often be significant to those with special health needs. There is no cost sharing in New Hampshire Children's Medicaid. Families would face considerably higher out-of-pocket costs for their children's health care in a Qualified Health Plan (QHP); for lower-income families that might be anywhere from 2.2 to 8.3 times higher than a separate CHIP program,[3] more so in a CHIP Medicaid Expansion state like New Hampshire. The impact on children with special health care needs could be devastating—some families could go from paying

[2] Onpoint Health Data for NH DHHS. *Children's Health Insurance Programs in New Hampshire.* June 2013.

[3] Brooks, T., Heberlein, M., Fu, J. *Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs.* Georgetown University Health Policy Institute Center for Children and Families. May 2014.

nothing in CHIP to facing more than $5,000 in annual out-of-pocket costs in QHPs.[4] Some of these current services in New Hampshire have limited or no coverage in Marketplace or commercial plans, e.g., dental, audiology exams and hearing aids, non-emergent transportation and Early Periodic Screening, Diagnosis and Treatment services. Of particular concern to children's well-being is dental care. Families will forego dental care if it means purchasing a stand-alone dental plan with additional premiums and cost sharing that doesn't count toward their medical deductibles and out-of-pocket maximum.

It is too early to tell how the Marketplace plans will serve children in New Hampshire. Several new carriers offering multiple health plans are poised to enter the Marketplace for 2015 after only one carrier participated in 2014. There are no plans in New Hampshire to require any benefits beyond the Essential Health Benefits and Early Periodic Screening, Diagnosis and Treatment (EPSDT) services as required for individuals that are 19 and 20 years of age who are found eligible for the NH Health Protection Program (PPACA Medicaid Expansion).

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP would become uninsured in the absence of CHIP?

Yes, CHIP funding should be extended through 2019 when the PPACA Maintenance of Effort (MOE) requirements ends. New Hampshire—as a Medicaid Expansion state—must cover this population through 2019 due to the federal government's MOE requirement. It would be catastrophic if New Hampshire were obligated to continue CHIP without relief from the MOE requirement. While Medicaid funding would not run out, NH's contribution to covering these children would increase significantly. Cost increases would need to be offset by other Medicaid cuts at a time when we are developing a new system of care. New Hampshire is one of the states that would be subject to an inequitable financial impact as states with separate CHIP programs would end those programs when CHIP funding expired.[5]

Congress needs to address this issue as soon as possible. New Hampshire is building its 2016–2017 biennium budget it will be difficult planning for an uncertain outcome that would involve significant increased costs for covering these children.

During the time period Congress extends CHIP funding, it is imperative that analyses are done regarding the benefit packages, cost sharing and network adequacy of Marketplace plans and their impact on the needs of low-income children. If deemed necessary, Congress should act to revise Marketplace plan requirements for children. In particular, PPACA's affordability test (the "family glitch") that counts *only* the employee's cost of Employer Sponsored Insurance (ESI) has the potential to erase many of the gains made in reducing uninsurance among children, if CHIP funding ends and families cannot afford ESI but are prevented from accessing subsidies in the exchange.[6]

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

New Hampshire has been able to work within its annual allotment due to a July 2012 policy change that moved the children in the separate CHIP program to the CHIP Medicaid Expansion. The cost of the separate program was outstripping legislative appropriations and New Hampshire came dangerously close to capping enrollment and/or instituting a wait list for the first time in the history of its CHIP program (with CMS approval). Moving to a CHIP Medicaid Expansion allowed NH to stay within its legislative appropriation, continue to cover all eligible children, provide comprehensive benefits, and maintain its low rate of uninsured children.

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[4] Wakely Consulting Group. *Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans.* July 2014.

[5] MACPAC (Medicaid and CHIP Payment Access Commission). *Report to the Congress on Medicaid and CHIP.* June 2014.

[6] Sara Rosenbaum discusses two basic PPACA "design flaws" in her Milbank Quarterly Op-Ed piece (volume 92, Issue 3, 2014): inadequate cost-sharing help for low income families and the family "affordability" problem that bars families from accessing premium subsidies for their children.

Depending on what Congress does, it may not be necessary to further address unspent allotments if CHIP funding is temporarily extended while the critical analytical work that is needed is done.

6. Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that can help states do an even better job of enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?

As indicated in question #4, policy changes should focus on technical issues with the PPACA and their effect on enrollment of children and the resulting impact on the rate of uninsurance among children, which could erase many of the gains this nation has made in children's coverage. If Congress intends to end CHIP funding, it should put in place a temporary extension and focus its policy attention on the affordability, accessibility and appropriateness of Marketplace plans for children during an extension period.

In summary, the CHIP funding extension to 2019 will allow time for Congress to fix the existing Marketplace technical issues that left unattended, and in combination with not reauthorizing CHIP funding, will prove to be catastrophic for New Hampshire families. In addition the extension will allow time for the critical analytical work to be done that is required to support informed decision-making by Congress about the future of the CHIP funding. That analytic work includes, but is not limited to:

- Assessing the impact of the existing "family glitch," which could keep half of the children on CHIP from accessing Marketplace Plans;
- Ensuring that QHPs are designed to meet children's health care needs with attention to children with special health care needs;
- Examining cost sharing in order to arrive at a family contribution that is fair and encourages QHP enrollment and appropriate use of health care services;
- Assessing whether stand-alone dental plans and their additional cost sharing are appropriate; and
- Designing tools to help families choose the best coverage in the Marketplace for their children.

Thank you for this opportunity to offer New Hampshire's perspective. We recommend and request that Congress extends funding for CHIP through 2019 and uses the time to perform the careful analyses MACPAC and others are calling for to make certain that the cost-sharing and benefits in Marketplace plans are affordable and appropriate for children. It would be premature to eliminate support for this program without understanding the impact of such action without adequate time for states to do the necessary planning and budget adjustments.

With every good wish,

Margaret Wood Hassan
Governor

cc: Congressman Henry Waxman
Senator Ron Wyden
Senator Orrin Hatch
Senator Jeanne Shaheen
Senator Kelly Ayotte
Congresswoman Carol Shea-Porter
Congresswoman Ann Kuster
Katie Dunn, Associate Commissioner and Medicaid Director, NH DHHS

STATE OF NEW MEXICO

HUMAN SERVICES DEPARTMENT

MEDICAL ASSISTANCE DIVISION • PO BOX 2348—SANTA FE, NM 87504 • PHONE: (505) 827–3103
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Susana Martinez, Governor
Sidonie Squier, Secretary

Julie B. Weinberg, Director

October 30, 2014

The Honorable Ron Wyden
Chairman
Senate Finance Committee

The Honorable Orrin Hatch
Ranking Member
Senate Finance Committee

The Honorable Fred Upton
Chairman
House Energy & Commerce Committee

The Honorable Henry Waxman
Ranking Member
House Energy & Commerce Committee

Dear Congressmen:

Thank you for your July letter to governors seeking information and feedback about the Children's Health Insurance Program (CHIP), including policy recommendations for the program as Congress considers the future of CHIP and the reauthorization of funding beyond federal fiscal year 2015. As you rightly note, both Medicaid and CHIP are operated as state-federal partnerships, and New Mexico appreciates the chance to offer input about imminent policy and financial considerations. In response, we are pleased to answer your questions in greater detail.

CHIP Enrollment Status and Demographics

New Mexico administers CHIP as an expansion of Medicaid, rather than as a stand-alone program. While CHIP enrollees have some additional cost-sharing responsibilities that differ from traditional Medicaid (discussed in greater detail below), the program itself has the same benefit package, application process and administrative structure as children's Medicaid; and essentially operates as two separate categories to cover children ages 0–5 and 6–18 who do not meet the income maximums for Medicaid.

As of October 1, 2014, New Mexico covered just over 14,000 children under CHIP—a number that has grown significantly since last January, when New Mexico had approximately 7,500 CHIP enrollees. For children 0–5 years-old, income eligibility for CHIP is between 240–300 percent of the federal poverty level (FPL); and for children ages 6–18, income eligibility is between 190–240 percent FPL. Children in families with income below these thresholds are eligible for Medicaid.

Approximately 12 percent of CHIP enrollees are Native American, and about 55 percent reside in rural New Mexico counties. CHIP enrollees are generally considered a healthy population. In New Mexico, most children who are enrolled in CHIP receive services through a managed care organization (MCO), with the exception of Native Americans, who may opt-into or out of managed care.

ACA-Related Changes

The most noteworthy change that New Mexico made to its CHIP program as a result of the Patient Protection and Affordable Care Act (ACA) was the conversion of existing CHIP income thresholds to equivalent income limits based on the modified adjusted gross income (MAGI) methodology. Per Section 2101(f) of the ACA, New Mexico also created a specific sub-category of CHIP for children who lose Medicaid coverage at renewal due to the elimination of income disregards as a result of MAGI conversion. And, like most other Medicaid categories, CHIP is subject to the same streamlined application and renewal processes that are required by the ACA.

CHIP Benefits & Cost-Sharing

Since CHIP operates as an extension of Medicaid in New Mexico, the benefits that are available to CHIP enrollees include the full gamut of physical, behavioral, oral health, vision and Early and Periodic Screening, Diagnosis and Testing (EPSDT) services that are provided to the traditional Medicaid population. There are some notable benefit differences between CHIP and the health plans that are available via most New Mexico employers and the Health Insurance Marketplace, since these plans generally do not include dental services, eyeglasses, vision refraction and psychiatric residential treatment centers comparable to CHIP. The CHIP dental benefit package is the benefit source for stand-alone dental plan offerings available to children on the Marketplace.

New Mexico charges co-payments to CHIP recipients, as outlined below;

Co-Pay	Item or Service
$2	Prescription drug item (Not applied when the co-payment for a brand-name drug is applied.)
$3	Brand-name drug (Applied when there is a less expensive drug available.)
$5	Outpatient visit to a physician or other practitioner, dental visit, therapy session or behavioral health session
$8	Non-emergent use of the emergency room
$25	Inpatient hospital admission

These co-payments are far lower than the cost-sharing provisions of most other commercial and Marketplace health plans. New Mexico CHIP does not charge premiums or deductibles.

Future CHIP Funding

New Mexico receives a higher federal match rate for CHIP enrollees than it does for Title XIX Medicaid recipients, and this additional federal funding has allowed our state to provide health insurance to children whose families have too much income to qualify for Medicaid, but who may have historically struggled to afford the deductibles and premiums associated with private or employer-sponsored coverage. With the creation of the Health Insurance Marketplace and federally subsidized coverage options and cost-sharing reductions, private insurance is now more affordable than when CHIP began years ago. It is interesting to note that CHIP enrollment has increased substantially in New Mexico since last January, the reasons for which are unclear. While a portion of this enrollment increase may be a "woodwork" effect due to the ACA's individual mandate and the related outreach and visibility of new coverage options, the increase may also reflect that middle income families might be forgoing private coverage to take advantage of the greater affordability offered by CHIP.

CHIP reauthorization presents an opportunity for Congress to inventory and streamline the wide array of coverage and affordability options that are now available to moderate- and middle-income families. While New Mexico currently uses the federal Marketplace platform, our state is moving quickly toward implementation of a state-based Marketplace for the 2016 open enrollment period. Our experience to date has been that transitioning populations and coordinating coverage between Medicaid and the federally facilitated Marketplace is a clunky and challenging process; and fewer families than originally anticipated have been able or willing to purchase coverage through the Marketplace. Until New Mexico has a mature state-based Marketplace that can ensure a streamlined and seamless process for families in accessing coverage, our state believes that CHIP—and the federal funding that goes with it—will remain an important coverage option for New Mexico families.

No discussion about CHIP funding can be held without recognizing that all states are currently operating under the ACA's maintenance of effort (MOE) provision, which requires the continuation of pre-ACA Medicaid and CHIP coverage levels for children through 2019. Federal rules for maintaining eligibility are unclear should CHIP allotments be discontinued, and any Congressional action on CHIP funding must make clear that the MOE provision would not apply should federal funding for the program be reduced or disappear altogether.

CHIP Allotments

The CHIP allotment process and methodology have worked well for New Mexico, and we don't have any specific recommendations for change. Should you consider a new allotment process or methodology, we urge you to keep financial stability and predictability for states at the forefront of your deliberations. We are committed to slowing the growth rate of health care costs while improving the quality of care, especially in Medicaid and CHIP. Large swings in federal financial participation can inhibit those efforts. Given that New Mexico, like most other states, would exhaust federal CHIP allotments during fiscal year 2016 without funding reauthorization, we may need more flexibility and time to adjust to this funding change.

Reaching Uninsured Children

New Mexico agrees that Medicaid and CHIP have been at the frontlines of making headway in reaching uninsured children, and this has historically been where our state has focused much of its attention. In addition to New Mexico's comparatively high Medicaid and CHIP income thresholds, the state has worked hard to facilitate the easiest and most straightforward enrollment and eligibility processes possible—

including widespread use of presumptive eligibility for children and pregnant women, implementation of continuous eligibility for child categories, use of administrative renewals, and automatic deeming of newborns as Medicaid- or CHIP-eligible when born to a Medicaid-enrolled mother. These policies have greatly aided our state in not only enrolling uninsured children into coverage, but in facilitating greater retention and ongoing child health improvements. Our state encourages Congress to be innovative and flexible in thinking about how states might continue to develop similar strategies as it works through the CHIP reauthorization process.

In conclusion, let me thank you again for seeking consultation from the states on this important issue. If you have any questions or need additional information, please don't hesitate to let me know.

Sincerely,

Julie B. Weinberg, Director
Medical Assistance Division

STATE OF NEW YORK

EXECUTIVE CHAMBER

ALBANY 12224

ANDREW M. CUOMO
GOVERNOR

September 4, 2014

The Honorable Ron Wyden
Chairman
Committee on Finance
U.S. Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
U.S. Senate
104 Hart Office Building
Washington, DC 20510

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
2204 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Wyden and Upton, and Ranking Members Hatch and Waxman:

Thank you for your recent letter requesting information regarding the Children's Health Insurance Program (CHIP). New York State's CHIP program, Child Health Plus, has been in existence since 1990 and successfully provides comprehensive, affordable insurance coverage to uninsured children throughout the state,

The CHIP program has made an enormous difference in expanding health insurance coverage in New York. When CHIP was enacted, New York had over 800,000 uninsured children. Today, there are about 100,000 uninsured children, nearly a 90 percent decline. We appreciate your interest in collecting information to determine if funding should be continued beyond Federal Fiscal Year 2015. Below are responses to the information requested in your July 29, 2014 letter:

1. **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g., income, health status, demographics)?**

   New York's Child Health Plus program currently is a combination program, meaning children ages 6 to 18 between 100% and 133% of the Federal Poverty Level (FPL) are funded under Title XXI of the Social Security Act through a Medicaid expansion. The separate portion of the program provides subsidized coverage to children from birth through age 18 that are not eligible for Medicaid and in families with incomes under 400% of the FPL ($95,000 for a fam-

ily of four). Children in families over 400% of the FPL that are otherwise eligible for coverage may enroll in the program at full cost.

As of July 2014, approximately 476,000 children are covered by CHIP: 297,180 in the separate CHIP program and approximately 179,000 through the Medicaid expansion. Attached is additional information describing the demographic characteristics of children enrolled through the separate program, including enrollment by poverty level, immigration status and ethnicity.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act (PPACA)? How has the implementation of PPACA impacted the way your state administers CHIP?

The biggest change in the administration of the CHIP program as a result of the PPACA is that eligibility determinations are now being performed by the New York State of Health (NYSOH), New York State's health insurance marketplace. NYSOH is an integrated eligibility system for all programs available under the Affordable Care Act, Medicaid, Child Health Plus, and qualified health plans with and without tax credit and cost sharing reductions. Previously, eligibility determinations for Child Health Plus were performed by participating health plans and Medicaid eligibility determinations by local departments of social services.

Another significant change under the ACA is the use of Modified Adjusted Gross Income (MAGI). Previously, the Child Health Plus program used gross income in determining eligibility. Moving to MAGI resulted in changes such as no longer counting child support or worker's compensation coverage as income. In addition, household composition rules were changed under ACA. The household composition is now based on the tax filing household.

Other changes have been made as a result of the ACA to more closely align the separate CHIP program with Medicaid eligibility rules.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

The Child Health Plus program offers subsidized health insurance coverage to children under 400% of the FPL. There are no co-payments or deductibles in the program. Depending on household income, families may be responsible for a monthly premium contribution. Family contribution levels are as follows:

<160% of the FPL	Free
160 to 222% FPL	$9 per child per month/$27 per month family maximum
223 to 250% FPL	$15 per child per month/$45 per month family maximum
251 to 300% FPL	$30 per child per month/$90 per month family maximum
301 to 350% FPL	$45 per child per month/$135 per month family maximum
351 to 400% FPL	$60 per child per month/$180 per month family maximum
Over 400% FPL	Full premium which varies by participating health plan

Child-only policies are available through the NYSOH at a considerably higher cost than Child Health Plus. The child-only policies available within NYSOH have a monthly premium that ranges from $175 to $287 per month as well as cost sharing provisions that range from $15 to $1,500 per service depending on the coverage level. Deductibles for these policies range from $0 to $3,000 depending on income. As noted above, there are no copayments or deductibles in Child Health Plus, and for families with incomes below 400%, FPL the maximum premium contribution is $180 per month depending on income. In New York State, 62% of all enrollees in Child Health Plus pay less than $9 per month.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state will be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

New York State strongly recommends that CHIP funding be extended. We believe funding through 2019 is the appropriate length of time for an extension. A more informed decision regarding the continuation of the program can be made after NYSOH has had several years of experience.

If the decision is made to not reauthorize CHIP funding, New York believes that states need at least twelve months of lead time in order to plan for, notify, and efficiently transition children to other programs. If the decision is not made with enough lead time, there is the potential that many children covered in the program will become uninsured. Even with sufficient lead time, we anticipate that many children may become uninsured if CHIP were discontinued given the large cost differential between Child Health Plus and the child-only policies on NYSOH.

5. In spite of restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

To date, New York State has received sufficient funding to support its Child Health Plus program through annual allotments and expansion allotment adjustments. With the potential for program growth under the ACA, New York anticipates there may be a need for increased allotments in the future.

6. Over the past number of years, States have worked to reduce the number of uninsured children and Medicaid and CHIP have been a critical component in that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any would help improve enrollment of eligible children, reduce the number of uninsured and improve health outcomes for children in your state?

New York believes that performance bonuses available under the Children's Health Insurance Program Reauthorization Act (CHIPRA) were an effective means of increasing enrollment under the programs. We suggest that the provision to reinstate performance bonuses be reauthorized.

Thank you again for your consideration in reauthorizing CHIP funding. Should you have any further questions, please feel free to contact Judith Arnold, New York State's CHIP director and the director of the Division of Eligibility and Marketplace Integration.

Sincerely,

Courtney Burke
Deputy Secretary for Health

Attachment

Cc: Jason Helgerson, New York State Medicaid Director
Judith Arnold, CHIP Director, New York State

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NYS CHILD HEALTH PLUS PROGRAM

Household Income—Federal Poverty Level	Enrollment*	% of Total
<160% FPL	74,165	25%
160–222% FPL	109,451	37%
223–250% FPL	35,664	12%
251–300% FPL	36,582	12%
301–350% FPL	20,709	7%
351–400% FPL	11,598	4%
>400% FPL	9,011	3%
Grand Total	297,180	100%

NYS CHILD HEALTH PLUS PROGRAM—Continued

Household Income—Federal Poverty Level	Enrollment*	% of Total
Total Subsidized	288,169	97%
CITIZENSHIP		
Citizen	256,757	86%
Qualified Immigrant	8,335	3%
Unqualified Immigrant	32,088	11%
Total	297,180	100%
RESIDENCE		
NYC	104,276	35%
Rest of State	192,904	65%
Total	297,180	100%
ETHNICITY		
Asian	23,157	8%
Black	19,340	7%
Hispanic	46,830	16%
American Indian	311	0%
Pacific Islander/Hawaiian N.	230	0%
Unknown	85,668	29%
White	121,644	41%
Total	297,180	100%

*July 2014 Enrollment

North Carolina Department of Health and Human Services
Division of Medical Assistance

www.ncdhhs.gov
Tel 919–855–4100 • Fax 919–733–6608
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Mailing Address: 2501 Mail Service Center • Raleigh, NC 27699–2501
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Pat McCrory
GOVERNOR

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

Robin Gary Cummings, M.D.
Deputy Secretary for Health Services
Director, Division of Medical Assistance

November 10, 2014

The Honorable Ron Wyden
Chairman
Senate Finance Committee
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Fred Upton
Chairman
House Energy & Commerce Committee
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Orrin Hatch
Ranking Member
Senate Finance Committee
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Henry Waxman
Ranking Member
House Energy & Commerce Committee
2204 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Wyden, Ranking Member Hatch, Chairman Upton and Ranking Member Waxman:

On behalf of Governor Pat McCrory, I am responding to your recent letter asking for North Carolina's input on the Children's Health Insurance Program (CHIP). We have provided detailed responses and data that may assist in your discussions on CHIP reauthorization.

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

North Carolina has four groups of children funded under Title XXI of the Social Security Act, the Children's Health Insurance Program (CHIP):

PROGRAM	AGE RANGE	FAMILY INCOME ELIGIBILITY
Medicaid expansion	Birth–12 months	186–200% FPL
Medicaid expansion	13 months–5 years	134–200% FPL
Medicaid expansion	6–18 years	101–133% FPL
Separate CHIP Program	6–18 years	134–200% FPL

Note: Federal Poverty Limit (FPL)

Under the Medicaid expansion programs, children receive the full range of Medicaid services paid for using Title XXI (CHIP) funds. These children are considered enrolled in Medicaid. Title XXI funding, with its enhanced Federal matching rate, allows North Carolina to provide these children with a richer array of services necessary early in life at a reduced cost to the State.

NC Health Choice program beneficiary enrollment in July 2014 exceeded 82,000. NC Health Choice beneficiaries reside in all 100 counties, but the number of beneficiaries varies from only 57 in one coastal county to more than 5,700 in one southwestern county. The average number of NC Health Choice beneficiaries per county is 821. See the figures below for the beneficiary age distribution, gender distribution, and income distribution.

Figure 1: NC Health Choice Beneficiaries by Age: July 2014

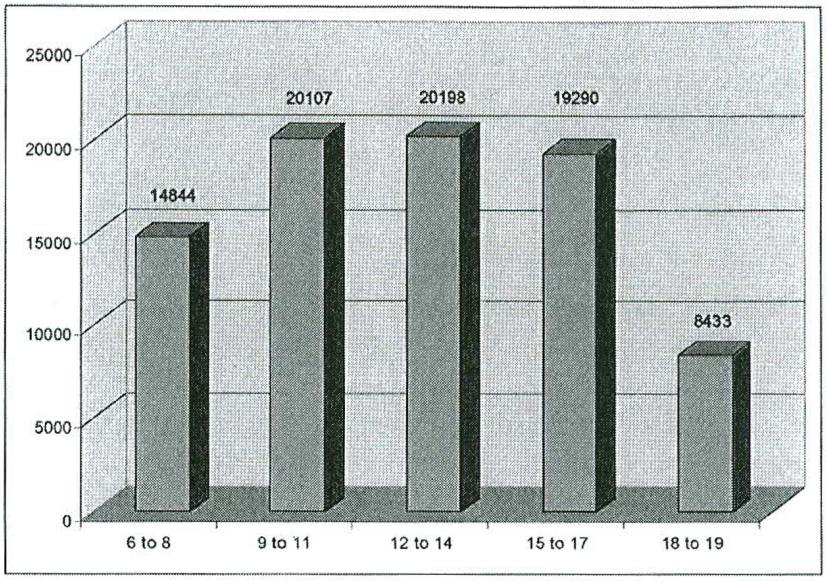


Figure 2: NC Health Choice Beneficiaries by Gender: July 2014

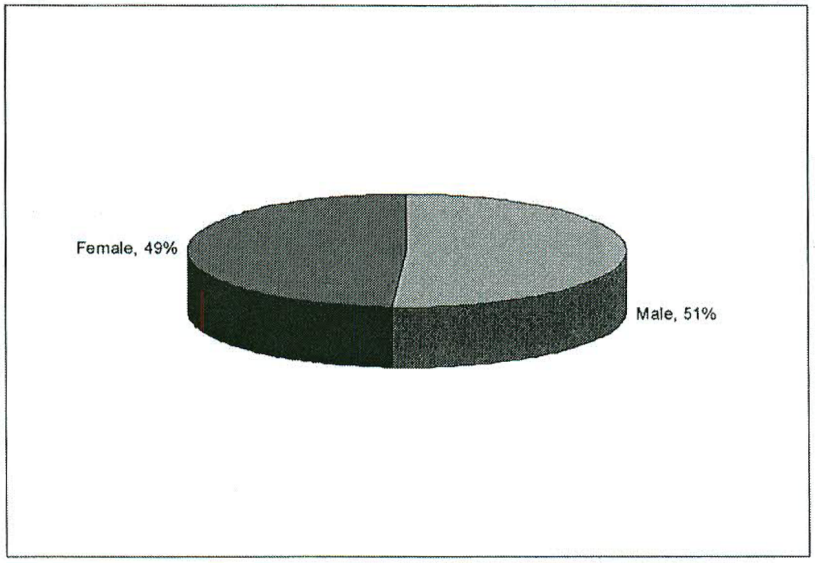
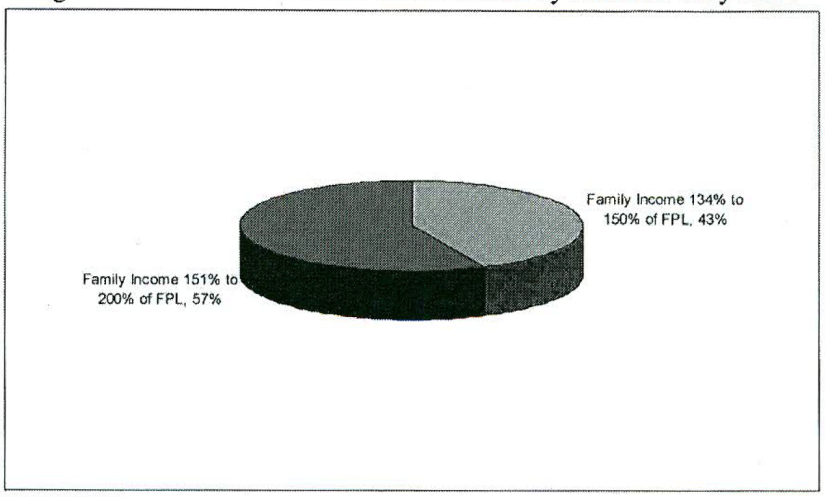


Figure 3: NC Health Choice Beneficiaries by Income: July 2014



2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

As a part of Affordable Care Act implementation, North Carolina modified its Health Choice Program eligibility to reflect the new Modified Adjusted Gross Income (MAGI) requirements that expand Medicaid for children to 133 percent FPL. As a result, approximately 72,000 children aged 6 through 18 who were previously eligible for NC Health Choice became eligible for Medicaid coverage on January 1, 2014.

Other than the new MAGI eligibility formula for both Medicaid and CHIP program applicants and the aforementioned shift in the income eligibility threshold, the Affordable Care Act has not affected the way that North Carolina administers the separate CHIP program. North Carolina uses one joint application for Medicaid and CHIP. Local county departments of social services workers screen applicants for Medicaid first. If household income exceeds Medicaid limits, workers then screen applicant s for CHIP.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Benefits coverage for the North Carolina CHIP program is controlled by federal Title XXI statutes, NC General Statutes, and the Centers for Medicare and Medicaid Services (CMS)-approved State Plan. NC Health Choice program services covered include many but not all of those allowable under federal Title XXI law:

- Inpatient hospital services;
- Outpatient hospital services;
- Physician services;
- surgical services;
- Clinic services, including ambulatory health centers and local health departments;
- Pharmacy benefits;
- Laboratory services;
- Radiological services;
- Mental health services;
- Durable medical equipment and medical supplies;
- Nursing services;
- Substance abuse treatment;
- Case management;
- Care coordination;
- Specialized therapies;
- Hospice care;
- Emergency medical transportation; and
- Preventive and restorative dental services.

Detailed Division of Medical Assistance Clinical Coverage policies for NC Health Choice program benefits are located at *http://www.ncdhhs.gov/dma/mp/index.htm.*

North Carolina General Statutes mandate that the separate CHIP program benefits be equivalent to Medicaid benefits. There are a few exceptions, as outlined in N.C.G.S. 108A–70.21(b):

(1) No services for long-term care;
(2) No non-emergency medical transpo1tation;
(3) No federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements; and
(4) Restricted dental services.

Cost sharing for the NC Health Choice Program is also outlined in the General Statutes and the CMS-approved State Plan. N.C.G.S. 108A–70.21(d) and (e) outline that there is no cost-sharing for families with incomes below 150 percent FPL, except for a $1 copay on generic prescription drugs and a $3 copay on brand name prescription drugs.

Families with incomes above 150 percent FPL are subject to greater cost-sharing, including a $5 copay for provider visits and outpatient hospital visits, excluding well-baby, well-child, or immunization visits. There is also a $1 copay for generic prescriptions, a $10 copay for brand name prescriptions, and a $20 copay for non-emergency emergency department visits. Overall cost-sharing per family cannot exceed 5 percent of the family's annual income.

The table following shows a comparison of NC Health Choice cost sharing with the North Carolina's Teachers and State Employees Health Plan (SHP) benefit plan and a Silver Blue Cross Blue Shield (BCBS) plan on the Federally Facilitated Marketplace (FFM). Both NC Health Choice and the FFM BCBS plan include medical and dental coverage; the SHP includes only medical coverage. The SHP insures nearly 700,000 State employees.

Income for a family of four living at 200 percent of the 2014 FPL is $47,700. This family income qualifies for NC Health Choice. Higher family income qualifies for both a health insurance premium tax credit and cost sharing reductions on the FFM. There are three broad qualifying criteria for the premium tax credit (See: *http://www.irs.gov/uac/Newsroom/The-Premium-Tax-Credit2*):

(1) the individual must purchase health insurance coverage through the FFM;

(2) household income cannot exceed 400 percent of the FPL; and

(3) the individual cannot be eligible for other coverage such as Medicare, Medicaid, or employer-sponsored coverage.

Cost sharing reductions are limited to Silver plans in the Bronze, Silver, Gold, Platinum continuum on the FFM. The SHP example in the table represents a 70 percent coverage/30 percent coinsurance plan option for comparison purposes because Silver plans have 70/30 coverage.

Comparison of NC CHIP, Employer-Sponsored, and FFM Health Insurance Cost Sharing

	NC Health Choice	NC Teachers and State Employees 70/30 Health Plan with BCBS (SHP)	NC Federally Facilitated Marketplace 70/30 Silver Plan with BCBS
Monthly Premium	(individual) $0 (family) $0 Annual enrollment fee of $50 per child or $100 per family for applicants living at 151%–200% of FPL	(individual employee) $0 for employee; paid by the State (employee + 1 or more children) $205.12 (employee + spouse + 1 or more children) $562.94	(individual child) $139 **
Annual Deductible	(individual) $0 (family) $0	(individual) $933 (family) $2,799	(individual child) $5,000 (Pharmacy) $200
Coinsurance	(individual) $0 (family) $0	(individual) 30% of eligible expenses *after* deductible (family) 30% of eligible expenses *after* deductible	
Coinsurance Maximum (*excludes* deductible)	(individual) 5% of household income, or $2,385 * (family) 5% of household income, or $2,385 *	(individual) $3,793 (family) $11,379 (pharmacy) $2,500	(individual child) $6,350 ** (pharmacy) $0
Preventive/Wellness Visit co-payment	$0 for all beneficiaries	$35 primary care $81 specialist	$25 primary care
Other Provider Office Visit Co-payment	$0 for beneficiaries living at 134%–150% of FPL $5 for beneficiaries living at 151%–200% of FPL	$35 primary care or mental health $81 specialist	$25 primary care $50 specialist
Inpatient Hospital Co-payment	$0 for all beneficiaries	$291 co-pay, then 30% *after* deductible for hospital services 30% after deductible for provider services in the hospital	30% *after* deductible
Prescription Drug Co-payment	• $1 generic for all beneficiaries • $3 brand if generic available for beneficiaries living at 134%–150% of FPL • $10 brand if generic available for beneficiaries living at 151%–200% of FPL	Range of $12–$125 tiered co-pays depending on tier *and* brand if generic available	*After* deductible: • $10 generic • $50 preferred • $70 non-preferred

**For a family of 4 living at 200% of the 2014 federal poverty level ($47,700).*

***Before any applicable premium tax credits or cost sharing reductions. See: http://www.shpnc.org/library/pdf/annual-enrollment/2015/med-prime-comp-chart.pdf, State Health Plan 70130 plan and https://www.healthcare.gov/find-premium-estimates/#results/&aud=indv&type=med&state=NC&county=Durham&ageO=10&employerCoverage=no&householdSize=4&income, Blue Value Silver 5000.*

In North Carolina's FFM, a BCBS's 70/30 Silver plan monthly premiums for a 10 year-old child is $ 139/month, with an individual maximum deductible of $5,000/year and an individual maximum. coinsurance of $6,350/year, adding up to approximately $13,000/year in annual out-of-pocket expenses for only one child before any premium tax credits or cost sharing reductions. For NC Health Choice, maximum out-of-pocket expense would be only 5 percent of household income or $2,385 for a household with one *or more* children.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absences of CHIP?

According to the NC Institute of Medicine's (NCIOM) 2013 *Child Health Report Card,* "More than 160,000 children in NC slipped into poverty during the recent recession, as the percentage of poor children increased from 19.5 percent of the child population in 2007 to 26 percent—more than one in every four children—in 2012." However, the NCIOM reported that in a five year period from 2007 to 2012, the percentage of uninsured children living under 200 percent of the FPL in North Carolina decreased from 20.6 percent to 11.4 percent. The report also states that the number of children covered by public health insurance (Medicaid or NC Health Choice) rose from 896,792 in 2007 to l,135,016 in 2012. 4. (See: NC Institute of Medicine, 2013 Child Health Report Card,
http://www.nciom.org/wp-content/uploads/2013/12/2013_CHRC-121913hi.pdf).

North Carolina supports extended funding of the CHIP program beyond federal fiscal year 2015. In North Carolina alone, based on the July 2014 enrollment statistics, 80,000 children would become uninsured in the absence of CHIP. And as long as household income remains at or above 134 percent of the federal poverty level, those children would not qualify for Medicaid. They would therefore only be eligible for employer-sponsored or private health insurance coverage in a plan available on the Federally Facilitated Marketplace.

If CHIP program funding is not extended, there will be fewer insurance options for children living in low-income families in North Carolina. Although comparable benefits may be available in the FFM, low income families' out-of-pocket expenses may be higher than they are for low income families with children enrolled in the North Carolina CHIP Program. The side by-side comparison in the table shows that cost sharing could be a prohibitively expensive factor for families even if their children qualify for insurance on the FFM, depending in part on the amount of applicable premium tax credits or cost sharing reductions.

Federal legislators and administrators at the Centers for Medicare and Medicaid Services already know that program beneficiaries "churn" back and forth within the CHIP and Medicaid programs as a result of low income families' sometimes transient or even seasonal work and fluctuating income statuses. When family income temporarily becomes too high for CHIP program eligibility but too low to allow a family to afford a private insurance policy on the FFM, the children in those families will be at risk for being uninsured, gaps in coverage, and limited to no access to preventive screenings, treatment, prescription medications, or behavioral health interventions for chronic conditions. Cost-effectiveness studies have shown that preventive care saves millions of dollars in long-term treatment for preventable chronic conditions and co-morbidities. CHIP program funding is therefore an investment in the health and future of North Carolina's and America's low income children.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

Federal allotments received for the North Carolina CHIP program have been sufficient to fund operations within the framework of the existing State budget for the program. North Carolina recommends that any modifications to the formula addressing unspent allotments should account for the shift of previously eligible children from CHIP programs to State Medicaid programs as a result of the Affordable Care Act MAGI eligibility threshold changes.

6. Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

North Carolina's outreach and enrollment processes have been very effective. North Carolina has qualified for Children's Health Insurance Program Reauthorization Act (CHIPRA) Performance Bonus awards for enrollment and retention for the past

three consecutive years. Given the enhanced outreach inherent to FFM implementation and successful State outreach and enrollment in recent years, North Carolina does not have any policy recommendations or requests for improvements for federal program enrollment regulations.

However, North Carolina encourages increased flexibility in the design and implementation of our health care delivery systems and federal funding streams so that we may address the unique needs of North Carolinians.

Thank you again for your letter. Please feel free to contact me or my staff if you need any additional information.

Sincerely,

Robin Cummings, MD
Director

cc: Governor Pat McCrory, State of North Carolina
Secretary Aldona Wos, MD, North Carolina Department of Health & Human Services

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Jack Dalrymple, Governor
Maggie D. Anderson, Executive Director

October 28, 2014

Representative Fred Upton
Chairman
House Committee on Energy and Commerce

Representative Henry A. Waxman
Ranking Member
House Committee on Energy and Commerce

Senator Ron Wyden
Chairman
Senate Finance Committee

Senator Orrin G. Hatch
Ranking Member
Senate Finance Committee

Re: State of North Dakota's Insight on CHIP

Dear Congressmen:

Governor Dalrymple has asked me to respond to your request for responses to questions you posed in your July 29, 2014, letter about the Children's Health Insurance Program (CHIP). Following are the North Dakota responses to your questions.

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

   As of July 1, 2014, approximately 3,200 children are served by North Dakota's CHIP. The income level is set at 175% of the Federal Poverty Level using Modified Adjusted Gross Income (MAGI). Children are enrolled through age 18.

Out of the 3,200 children enrolled, there are 430 American Indian children enrolled.

For the 12 months of calendar year 2013, there were 1,507 children that had coverage for the 12 calendar months. Of those 1,507:

- 79% (1,180) of children enrolled in Healthy Steps have been seen by a primary care provider.
- 71% (87) age 13 (122 children age 13 had continuous coverage) have received meningitis and T–Dap vaccines.
- There were 139 children with Asthma.
- There were 20 children with Type 1 diabetes.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act.? How has the implementation of PPACA impacted the way your state administers CHIP?

   As required in the Affordable Care Act, on January 1, 2014, eligibility determination for Medicaid and the Children's Health Insurance Program changed to use Modified Adjusted Gross Income (MAGI). This new eligibility determination process does not allow the use of income disregards. Children previously enrolled in Medicaid who are no longer eligible for Medicaid due to the elimination of income disregards are eligible for coverage through CHIP for 12 months. This 12-month CHIP eligibility period is intended as a way to ensure a smooth transition and continuity of coverage for children as the new income eligibility rules in the Affordable Care Act take effect. After the 12-month coverage period, the family will be able to apply again for health care coverage and if the family no longer qualifies for Medicaid or CHIP, they will be directed to apply for coverage inside or outside the Federal Marketplace.

   The Department began transitioning children in April 2014, and the transition will be ending in December 2014. In accordance with the ACA mandates, North Dakota no longer allows a three-year average for self-employed individuals for income determination. This appears to be having an impact on families who report farm income.

   Prior to the ACA, North Dakota policy included a six month waiting period for dropped coverage (crowd out period). In accordance with the requirements in the ACA, the waiting period has been reduced to 90 days.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

   This information is not available.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

   The North Dakota CHIP has been successful and has been supported by policy makers and many advocacy organizations. The Executive Budget request for the 2015–2017 biennium assumes continued federal CHIP funding. The North Dakota legislative session will be January through April 2015, so a funding decision as soon as possible would be appreciated. The Department of Human Services' does not have information available to estimate the coverage options that would be available for children should CHIP funding cease. We could expect that some children may be able to join the coverage policy from a parent or access coverage through a child-only policy. However. we do not collect or maintain information that allows us to estimate the percent of children that would retain some type of low cost or free coverage or the percent of children that may become uninsured.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately?

Yes, the funding formula has been sufficient for North Dakota. Currently we are carrying over and spending the remaining previous federal fiscal year allotment within the second quarter of the subsequent federal fiscal year.

Do you believe there is a need for Congress to further address the issue of unspent allotments?

North Dakota has not had significant, multiple-year unspent allotments and we do not have perspective to provide a recommendation on this.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children?

The alignment of federal policies could strengthen enrollment efforts. For example, guidelines for determining family/household based income being consistent across similar economic assistance programs such as:

SNAP = Supplemental Nutrition Assistance Program
TANF = Temporary Assistance for Needy Families
CCA = Child Care Assistance Program

What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

North Dakota does not have additional policy change suggestions.

Thank you for your work to look at funding for the Children's Health Insurance Program. Should you have any additional questions, please contact me or Governor Dalrymple's Health and Human Services policy advisor, Tami Ternes.

Sincerely,

Maggie D. Anderson
Executive Director

State of Ohio
Department of Medicaid

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John R. Kasich, Governor
John B. McCarthy, Director

November 6, 2014

Chairman Fred Upton
House Committee on Energy and Commerce
2183 Rayburn House Office Building
Washington, D.C. 20515

Chairman Upton,

On behalf of Governor John Kasich, I would like to thank you for the opportunity to weigh in on the debate over funding for the Children's Health Insurance Program (CHIP). Ohio remains committed to improving the health and well-being of its children and looks forward to working with the Federal government to improve their future.

Ohio's CHIP program is administered as an extension of the Ohio Medicaid program covering children who come from households with income under 200% of the Federal Poverty Level. Children enrolled in CHIP have access to all Medicaid benefits including vision, dental, behavioral health services, physical health, and most importantly early periodic, screening, diagnosis and treatment (EPSDT) services. Additionally, there is no cost sharing for services. With the way Ohio has chosen to administer CHIP, there was no need for changes due to the Patient Protection and Affordable Care Act (PPACA). Ohio currently covers 151,605 children under CHIP

with 51% of them being male and 49% female. Roughly 74% of the population is Caucasian, 23% African American, 2% Asian/Pacific Islander, and 1% listed other.

To continue our successes in connecting children to coverage, Ohio and other states need clarity on what Congress plans to do sooner rather than later. A decision regarding tens of millions of dollars requires ample time for states to properly budget. Should the Federal government choose not to fund CHIP, Ohio must continue to cover the children and the services they receive unless there is a corresponding change in the Federal Maintenance of Effort (MOE) requirement under the Affordable Care Act. That would mean a reduction in the federal matching percentage for those services from 73.85% to 62.64%, which equates to an 11.21% cut in funding to the state. The difference would have to be covered by state dollars which would cause a significant budget deficit. The timeline for Ohio's budget process sees a budget bill being introduced in early February with passage occurring prior to the start of a new state fiscal year on July 1, 2015. This needs to be taken into consideration when Congress makes their decision moving forward. Ohio's CHIP allotment has worked well for the state and has sufficiently covered all of its CHIP expenditures, therefore Ohio does not recommend any changes in that area.

Ohio's children remain a priority and through Medicaid, CHIP, and private insurance, Ohio has covered roughly 9% of its children. Ohio has received over $63 million since 2010 in Children's Health Insurance program Reauthorization Act of 2009 (CHIPRA) bonuses. CHIPRA dollars have gone on to fund and supplement funding for modernization of the Medicaid program and for innovative strategies in providing services. Ohio has also made a major step towards simplifying enrollment. On October 1, 2013. Ohio launched *Ohio Benefits,* a simple, self-service website that makes it easier for Ohioans to sign up for the health care coverage that may be available to them. Through July 31, 2014, this system has processed over 825,000 applications. The success of this system comes from coordination from the state and local government entities.

Thank you again for the opportunity to explain Ohio's Children's Health insurance Program. Please let me know if you need any further information.

Sincerely,

John B. McCarthy
Director
Ohio Department of Medicaid

Cc: Ranking Member Henry A. Waxman, House Committee on Energy and Commerce
Chairman Ron Wyden, Senate Finance Committee
Ranking Member Orrin Hatch, Senate Finance Committee

Mary Fallin
Office of the Governor
State of Oklahoma

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October 29, 2014

The Honorable Ron Wyden
Chairman
Committee on Finance
U.S. Senate
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
U.S. Senate
104 Hart Office Building
Washington, DC 20510

The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
2204 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Wyden and Upton, and Ranking Members Hatch and Waxman:

On behalf of the state of Oklahoma, I am pleased to submit this reply to the July 29 Congressional correspondence requesting our input on the continuation of Children's Health Insurance Program (CHIP) funding beyond Federal Fiscal Year (FFY) 2015.

Since 1997, Oklahoma's CHIP children have been enrolled in SoonerCare, the Oklahoma Medicaid program, which is currently a combination program. Members qualifying for SoonerCare under the CHIP program are under age 19 and have incomes between the maximum for standard Medicaid eligibility and 185 percent of Federal Poverty Level (FPL) guidelines. The majority of these CHIP children are enrolled in an integrated health care delivery system, SoonerCare Choice, which is a patient-centered medical home program. Since 2010, through Insure Oklahoma (a public-private premium assistance program) Oklahoma has been providing subsidized coverage through qualified small business employers to children from birth through age 18 who are not eligible for Medicaid and in families with incomes from 186 percent through 200 percent of FPL, as well as pregnancy-related benefits to some Medicaid-ineligible pregnant women.

Below are responses to the six questions outlined in your correspondence:

1. **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g., income, health status, demographics)?**

   In State Fiscal Year (SFY) 2014, Oklahoma had 155,718 unduplicated CHIP enrollees in its SoonerCare programs. Attached is additional information describing the demographic characteristics of this population.

2. **What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act (PPACA)? How has the implementation of PPACA impacted the way your state administers CHIP?**

   Oklahoma's real-time online enrollment system for SoonerCare, operational since September 2010, required significant and costly modification to its rules engine and single streamlined application to comply with the PPACA Modified Adjusted Gross Income (MAGI) standard. Because of the PPACA eligibility changes for income and household com position, extensive training modules were developed for both Medicaid agency staff as well as contracted call center staff in order to effectively assist Oklahoma families with children who were not eligible through the Federally Facilitated Marketplace (FFM). Because Oklahoma is an assessment state, the final eligibility determination is completed by the state's Medicaid agency. Overall, it is more complex and time consuming for Medicaid agency staff to accurately determine income under MAGI, adding an increased burden to Oklahoma.

   Oklahoma also made all necessary policy revisions and system changes to comply with the PPACA, including moving those children under 133 percent FPL from Title XXI to Title XIX.

3. **To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.**

   The majority of Oklahoma's SoonerCare CHIP children are enrolled in the Medicaid/CHIP combination program. As required by CMS, these children receive comprehensive medically necessary benefits, including non-emergency transportation, dental and vision care. These services are offered within the Medicaid cost sharing limitations.

   SoonerCare coverage for children, with CMS required benefits and wrap around services, is equal to Federally Facilitated Marketplace plans with a 90 percent actuarial value. Premiums for a comparable child-only plan for a 12-year-old in Oklahoma County, excluding dental and vision, currently range from $192 to $252 per month. There are premium variations across the state based on age, county of residence and scope of benefits.

4. **Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframes should Congress act upon an extension? If you do not believe CHIP**

funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state will be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

Yes, to allow time to resolve existing program or policy issues, such as the family glitch, and provide continuity of coverage to children, Oklahoma recommends the CHIP program be extended through FFY 2019. The family glitch refers to the situation in which employer-sponsored insurance for family coverage might prove too costly for low-income employees, even though affordable on an individual basis. This situation should be resolved during the extension period to ensure the health and financial security of our families and in a way that supports workers through enrollment in employer-sponsored health insurance. For state budgeting and planning purposes, Congress should take immediate action.

5. **Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?**

Since FFY 2013, Oklahoma's annual allotments have not been sufficient to cover our CHIP expenditures. However, the state had enough unspent allotments from previous years to bridge the gap between our annual allotments and annual expenditures. For FFY 2014, Oklahoma's projected CHIP expenditures will exceed the annual allotment. Once again, Oklahoma will rely on its unspent allotment for sufficient funding. With the continued pressure of program growth forced by the PPACA, Oklahoma expects there will be a need for increased allotments in the future.

Unspent allotments from each state might be more efficiently managed if Congress established and maintained a contingency fund for states that experience funding shortfalls.

6. **Over the past number of years, states have worked to reduce the number of uninsured children and Medicaid and CHIP have been critical components in that effort. Do you believe federal policies could help states do an even better job in enrolling eligible children? What other policy changes, if any would help improve enrollment of eligible children, reduce the number of uninsured and improve health outcomes for children in your state?**

I have stated health goals for Oklahoma that include improving population health outcomes, reducing the number of uninsured, increasing access to health services and improving the quality of care. To that end, I believe federal policies should support state managed programs to achieve these objectives. Oklahoma specifically supports the following programs and policies:

- Provide flexibility to states for innovation and reward that innovation through incentive programs (for example, the CHIP performance bonus program);
- Support quality measurement and improvement as a way to specifically address health outcomes through programs such as the CHIPRA pediatric quality measurement and improvement;
- Reduce the burden on states for the PPACA enrollments by extending the use of CHIP allotments to cover previously Medicaid-eligible children; and
- Create program efficiencies by establishing and maintaining a contingency fund for states with annual CHIP expenditures exceeding that state's annual allotment.

In conclusion, Oklahoma believes adoption of these recommendations would have a positive impact on health outcomes for our youngest citizens by improving access to quality preventive and primary health care.

Sincerely,

Mary Fallin
Governor

SoonerCare CHIP SFY 2014

Race	Medicaid/CHIP	CHIP Standalone *	CHIP Total
American Indian	19,009	191	19,200
Asian or Pacific Islander	3,285	661	3,946
Black or African American	12,950	274	13,224
Caucasian	93,768	6,847	100,615
Declined to Answer	4,758	212	4,970
Multiple Race	13,667	96	13,763
Total	**147,437**	**8,281**	**155,718**
Hispanic Ethnicity	*30,673*	*5,642*	*36,315*

Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Gender	Medicaid/CHIP	CHIP Standalone *	CHIP Total
Female	72,799	7,930	80,729
Male	74,638	351	74,989
Total	**147,437**	**8,281**	**155,718**

Age	Medicaid/CHIP	CHIP Standalone *	CHIP Total
Infant (0)	3,563	5	3,568
1–5	29,996	149	30,145
6–12	64,699	282	64,981
13–18	49,179	511	49,690
19 & Over **	0	7,334	7,334
Total	**147,437**	**8,281**	**155,718**

Age as of end of SFY (6/30/2014).
** Only Soon-To-Be-Sooners members can be 19 & Over.

Federal Poverty Level	Medicaid/CHIP	CHIP Standalone *	CHIP Total
100%–132%	66,424	5,995	72,419
133%–149%	23,915	548	24,463
150%–185%	57,098	1,738	58,836
Total	**147,437**	**8,281**	**155,718**

	Medicaid/CHIP	CHIP Standalone *	CHIP Total
Monthly Average Enrollment	76,870	3,201	80,071

* CHIP Standalone includes Soon-To-Be-Sooners (STBS) and Insure Oklahoma children. STBS provides limited coverage for pregnant women related to pregnancy-related health care services for the benefit of the baby.
Data valid as of 7/14/2014 and subject to change.

State of Oregon

JOHN A. KITZHABER, MD
GOVERNOR

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October 29, 2014

The Honorable Ron Wyden
Chairman

The Honorable Fred Upton
Chairman

Committee on Finance
U.S. Senate
Washington, DC 20510

Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Orrin Hatch
Ranking Member
Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Henry Waxman
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairmen Wyden and Upton, Senator Hatch, and Representative Waxman.

This letter is in response to correspondence to the state of Oregon from House Representative Fred Upton and Henry A. Waxman, and Senators Ron Wyden and Orrin G. Hatch regarding questions members of the bipartisan bicameral committees asked about the Children's Health Insurance Program (CHIP) and considering whether and how the program should be extended, and what, if any, additional policy changes should be made.

We strongly encourage you to pass a long-term extension of the CHIP program as soon as possible. It has been and continues to be invaluable in ensuring access to affordable health insurance coverage for thousands of families in our state. Without an extension of the program and the funding, many children would be at risk of not being covered since premium, co-pays and deductibles may be unaffordable for families. Also the benefits covered under our CHIP program ensure that children have affordable access to a broader range of services including dental care, physical and speech therapy and vision services.

Oregon's responses to these questions are included here:

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

There are 76,000 children enrolled in CHIP in Oregon as of June 15, 2014, about evenly split between males and females. We also cover over two thousand pregnant women who are Medicaid eligible except for their immigration status. Of children covered under the Oregon Health Plan (our Medicaid and CHIP program), CHIP children make up about 20%. The following tables show the income and demographics:

Age & Federal Poverty Level (FPL)	# enrolled as of June 15, 2014
<l–18 years old, 100–200%	58,772
<1–18 years old, 201–300%	17,726
Pregnant women	2.122
Total	**78,620**

Race	% of CHIP population
American Indian/Alaska Native	1.2%
Asian	3.4%
Black or African American	1.8%
Native Hawaiian/Other Pacific Islander	0.4%
White	57%
More than one race	0.5%
Unspecified Race/Unknown	35%

Ethnicity	% of population
Hispanic or Latino	16%

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

Oregon administers CHIP as a separate Medicaid "look alike" program. A couple changes made to the CHIP program since 2012 that were indirectly related to the ACA include:

- Transitioning the CHIP premium assistance commercial insurance option for children from 200–300% to direct coverage under for the Oregon Health Plan (the same as the CHIP program for children under 200% FPL), and increasing the income limits for children on OHP up to 300% FPL
- Per the ACA, some of the CHIP children (6–18 100%FPL–133% FPL were moved to Medicaid coverage (the "stair-step" children).

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or the cost sharing currently provided in your state that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Services not provided by Qualified Health Plans (QHPs) available at the Marketplace/Exchange and typically not available by employer sponsored insurance include:

- Pediatric Dental—QHPs are not required to provide, so generally enrollees must purchase a stand-alone dental plan with additional cost shares and premiums.
- Vision Senvices—Also available from QHPs, but with high deductibles, other cost shares, and limited benefits from QHPs. These services are not limited by our CHIP program.
- Hearing exams, hearing aids.
- Physical and speech therapy—QHPs have tighter limits on benefits than our CHIP program.
- Non-Emergent Medical Transportation—This benefit is not available through QHPs or employer sponsored coverage and transportation is frequently a barrier to access for children in lower income households.
- Enabling services—Sign language and translation/interpretation for individuals with limited English proficiency.

In addition, the QHPs have cost sharing requirements for both premiums and co-pays/deductibles that our CHIP program does not. Even when the family does qualify for tax credits, the affordability of the premium may be challenging since the affordability criteria only looks at an employee's employer coverage not what it costs to cover the family/dependent (the so-called "kid glitch").

4. Do you recommend that CHIP funding be extended? If so, for how long and for budgeting and planning purpose, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence or CHIP?

Oregon recommends extending CHIP funding at least through 2019. During an extended funding period, many of the key issues regarding the affordability and adequacy of children's coverage could be addressed, and states and the federal government would have time and opportunity to determine what strategies will work best for the future.

With CHIP funding currently scheduled to run out shortly after FY 2015, children now served by CHIP Likely would be left to find coverage elsewhere—the Marketplace or employers if available. It is unlikely that low-income families would be able to afford the coverage on the exchanges given the "kid glitch." Also, low income families may not be able to afford to purchase some of the additional benefits that Oregon's current children can access such as dental care, physical and speech therapies, or to be able to get to the care needed if they were to have transportation barriers. In addition, given our experience, we agree with the Medicaid and CHIP Payment and Access Commission (MACPAC) that transitions to the Marketplace likely not would be smooth and that many children would likely fall in with MACPAC data that as many as half of our CHIP kids may lose coverage, which would erase much of our coverage gains for children that we've made over the past five years.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

Given that CHIP is capped and is allotted states annually based on a methodology that relies on each state's recent CHIP spending and that states have two years to spend each allotment, Oregon has not experienced any challenges in running low on allotment funds nor in having excessive leftover funds at the end of a fiscal year. Congress should consider keeping in place and extending the safety net provisions of CHIPRA, however, in order to protect states and optimize the use of funds. Under these provisions, if a state should run out of allotment, there are options of applying for funds from (1) the CHIPRA contingency fund established by the 2009 legislation or (2) FY 2012 redistribution funds from states that did not exhaust their FY 2012 allotment after two years of availability.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help States do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

Oregon has seen dramatic decline in the number of uninsured children by more than six (6) percentage points since implementing the State's HealthyKids programs in 2009 and has a rate of uninsured children 1.5 percent lower than the national average. This success was due in large part to (1) the expansion in the income eligibility criteria to 300 percent of FPL for families of children (2) implementation of 12 month continuous eligibility for children, (3) the use of the option for Expedited enrollment using SNAP and (4) the use of premium subsidies for children in families who chose to have their children covered in the family's individual or group insurance coverage or through the HealthyKids Connect program's private coverage.

The state's implementation of the Coordinated Care model, and Patient Centered Primary Care Homes as part of the Health Systems Transformation effort to better integrate and coordinate care and provide a full scope of coverage has already shown measurable improvement in health outcomes and key indicators of population health. Oregon, therefore, would encourage Congress to continue to allow states these and other available flexibilities to enhance both numbers of insured and health outcomes for children and their families.

Sincerely,

John A. Kitzhaber, MD
Governor

Commonwealth of Pennsylvania

OFFICE OF THE GOVERNOR
HARRISBURG

October 31, 2014

Honorable Fred Upton
Chairman
Energy & Commerce Committee
2183 Rayburn House Office Bldg.
Washington. D.C. 20515

Honorable Ron Wyden
Chairman
Committee on Finance
221 Dirksen Senate Office Bldg.
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Honorable Henry Waxman
Ranking Member
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Honorable Orrin Hatch
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Dear Chairmen Upton and Wyden, and Ranking Members Hatch and Waxman:

Thank you for contacting Pennsylvania regarding the future of the Children's Health Insurance Program (CHIP) and how it should be extended. As the leader of a state with more than 157,200 children enrolled in CHIP, there is no question that funding for CHIP should be extended on a federal level. We must allow CHIP to continue to successfully provide quality, affordable health care coverage to children. Moreover, addressing this issue promptly is critical for providing certainty to CHIP families and making sure that children can stay with their health care providers.

CHIP works for kids. Pennsylvania's CHIP program (PA–CHIP) has provided vital health care coverage to hundreds of thousands of children in Pennsylvania for over 20 years and is an example of how states can develop innovative solutions to meet the needs of their residents. PA–CHIP was enacted in 1992, and five years later, when the federal CHIP was created, PA–CHIP was acknowledged as a national model for the federal health care coverage program for children. PA–CHIP continues to be one of the benchmark benefit packages recognized in the federal CHIP law.

Pennsylvania has worked tirelessly to continue providing PA–CHIP coverage as an option for children and their families. However, as you know, the passage of the Affordable Care Act (ACA) serves as a challenge for PA–CHIP because it forces an efficiently functioning program to conform to rigid federal standards. In addition to the ACA's overwhelming strain on the program's resources, the ACA has proved damaging to PA–CHIP's enrollment figures by requiring children in the 100%–133% Federal Poverty Level (FPL) range to be enrolled in Medicaid, rather than in CHIP.

Last year, Pennsylvania vehemently opposed a federal interpretation requiring an unnecessary transfer of children from PA–CHIP into Medicaid. I spoke personally with then Secretary Kathleen Sebelius and said no child in Pennsylvania should be forced to change health care coverage and potentially lose access to his or her health care provider needlessly. Unfortunately, this is the scenario we now face because of the ACA. While the Obama Administration ultimately refused to grant Pennsylvania a permanent waiver from this ACA requirement in order to protect the child/health care provider relationship, we did successfully secure additional time to prepare for the transition and keep children with their providers for as long as possible.

When extending federal funding for CHIP, I also would suggest that the federal government use this extension as an opportunity to improve upon the federal program for the betterment of Pennsylvania's children and children nationwide. For example, Federal authorities should consider structuring flexibilities into the program for states, such as allowing states with separate CHIP programs the option to enroll children above 100% FPL in CHIP or Medicaid. Additionally, federal authorities should consider "at-cost" CHIP to be Minimum Essential Coverage (MEC), therefore avoiding unnecessary tax consequences for families.

With the health care needs of Pennsylvanian's children at stake, the extension of federal funding is critical to retain PA–CHIP as an option for families seeking health care coverage for their children. Thank you for the opportunity to share the importance of the extension of federal funding for CHIP and what it will mean for Pennsylvania's children and their families. With regard to your specific questions, please find the responses attached.

I urge you to extend CHIP's federal funding, and I look forward to working with you to improve this successful program.

Sincerely,

TOM CORBETT
Governor

Enclosure

Attachment A

1. **How many individuals are served by you r state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?**

Pennsylvania CHIP population characteristics. (September 2014)

Income Range

Income Range	$0	< $10,000	< $20,000	< $30,000	< $40,000	< $50,000	< $60,000	> $60,000	Total
Enrollees	1,596	1,443	5,360	28,613	41,773	35,759	20,709	22,642	**157,895**

Ethnicity

Ethnicity	Unspecified	Hispanic	Non-Hispanic	Total
Enrollees	21,200	15,523	121,172	**157,895**

Race

Race	Unspecified	African American	Caucasian	Asian	Hawaiian/ Islander	Alaskan/ Indian	Asian (Indian)	Other Race	More Than One Race	Total
Enrollees	11,338	21,737	102,744	5,337	81	138	854	13,927	1,739	**157,895**

Gender

Gender	Female	Male	Total
Enrollees	78,493	79,402	**157,895**

Cost Category

Cost Category	Free (133%–208% FPL)	Low Cost 1 (208%–262% FPL)	Low Cost 2 (262%–288% FPL)	Low Cost 3 (288%–314% FPL)	At-Cost (314% FPL and above)	Total
Enrollees	120,637	23,395	5,895	4,512	3,456	**157,895**

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

As a result of the Affordable Care Act (ACA), Pennsylvania's CHIP (PA–CHIP) has faced tremendous operational and administrative challenges in order to comply with the requirements and expectations of the ACA, including but not limited to:

- Transitioned to the use of Modified Adjusted Gross Income (MAGI) to determine applicants' eligibility for PA–CHIP. The change to MAGI resulted in a complete reconfiguration of the methods by which PA–CHIP calculates applicants' income and determines applicants' household composition.
- Moved eligibility determinations out of the PA–CHIP Application Processing System and into a combined rules engine with the Medicaid program. PA–CHIP and the Medicaid program continue to work through discrepancies regarding eligibility, as the programs take different approaches to certain eligibility characteristics.
- Prepared for a transition of PA–CHIP enrollees ages 6–18 within 100%–133% FPL to the Medicaid program, consequently forcing enrollees to undergo an unnecessary transition of coverage and potential disruption in continuity of care.
- Implemented the "Single Streamlined Application" and renewal form. By changing the initial and renewal applications to remove requests for verifications prior to electronic verification sources being accessible, incomplete application and renewal forms accumulated to create a significant backlog. Each processing entity experienced significantly increased administrative workloads, and families experienced delays in processing and requests to produce paper verifications.

- Initiated coordination with the Federally Facilitated Marketplace (FFM) to transfer account information to and from the FFM. PA–CHIP faced significant challenges as the Federal Data Services Hub underwent inadequate testing and was not prepared to facilitate the transfer of the account information.
- Transitioned to Income Tax Rules, causing considerable confusion for a means tested program. Confusion as to the applicability of the rules to certain households' composition continues, as federal regulators are still interpreting certain rules as to when or how income should be counted.

Currently, Pennsylvania administers a Title XXI CHIP through nine private insurance companies serving as contractors. (Title XXI of the Social Security Act allows states to operate a stand alone CHIP program, separate and apart from a Title XIX Medicaid program.) The contractors provide healthcare benefits to the children, and are responsible for certain portions of the eligibility and enrollment process. Pennsylvania is the only state with this type of arrangement. In response to the ACA, along with the passage of the CHIP Reauthorization Act of 2009, PA CHIP is performing a holistic assessment of the administration of the program to identify areas of possible administrative improvement. The review has thus far demonstrated the benefit of a Title XXI CHIP, and the corresponding use of contractors, as this administrative framework allows CHIP to operate very efficiently.

The ACA also impacted PA–CHIP's "Buy-In" program, which allows families with incomes greater than 300% FPL [1] to purchase the PA–CHIP benefit package at no cost to the state or federal government. Even though the Buy-In program maintains the same eligibility requirements and benefit package as the subsidized PA–CHIP, federal authorities have not yet concluded the Buy-In program constitutes Minimum Essential Coverage (MEC) for enrollees. Without this conclusion, enrollees in the Buy-In program may face penalties pursuant to the ACA's individual mandate if other coverage is not secured.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

As a preliminary note, in a study performed by Deloitte Consulting, LLP (Deloitte) for Pennsylvania in August 2012, Deloitte analyzed the ten benchmark options for the exchange and concluded, among other things, that there was little variation in the benchmark options. Thus, for purposes of this response, the PA benchmark benefits and the majority of employer sponsored health plans in the state are assumed to be parallel, and our comments will focus on comparing PA–CHIP benefits and the PA benchmark benefits.

Cost-Sharing

PA–CHIP has graduated levels of premiums and cost-sharing based on income level.[2] Under PA law, Free PA–CHIP covers children in families with an adjusted gross household income no greater than 200% of the FPL. There are no premiums and no co-payments collected for enrollees in this group. Low-cost PA–CHIP covers children in families with an adjusted gross household income greater than 200% but no greater than 300% of the FPL; these enrollees pay modest premiums.

Children in Low-cost PA–CHIP also are charged point-of-service co-payments for primary care visits ($5), specialists ($10), emergency room care ($25, waived if admitted), and prescriptions ($6 for generic and $9 for brand names). There are no co-payments for well-baby visits, well child visits, immunizations, or emergency room care that results in an admission. Co-payments apply to physical health services but are no applicable to routine preventive and diagnostic dental services or vision services. Cost sharing for PA–CHIP, the combination of premiums and point of service co-payments, is capped by federal CHIP regulation (42 C.F.R. 457.560) at 5% of household income.[3]

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[1] Factoring in the ACA MAGI rules, 300% FPL is effectively 314% FPL.

[2] As noted above, PA–CHIP also has a full-cost component for those above 300% FPL, which is not subsidized by either federal or state dollars. In keeping with the focus of the Congressional inquiry, this cost-sharing discussion addresses only the subsidized components.

[3] 42 C.F.R. § 457.560(a): "A State may not impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, exceed 5 percent of a family's total income for the length of a child's eligibility period in the State."

In summary, PA–CHIP enrollees pay modest premiums, depending on income level, and have limited cost-sharing:

Income Federal Poverty Level (FPL)	Premium as a % of the Per Member Per Month (PMPM) Cost	Approximate Average Premium Cost to Enrollee Per Month as of September 5, 2014	Total Premium Plus Cost-Sharing Per Year as % of Household Income
<201% FPL	0%	$0	0%
201% FPL–250% FPL	25%	$50.25	5%
251% FPL–275% FPL	35%	$70.35	5%
276% FPL–300% FPL	40%	$80.40	5%

By comparison, premiums for the second lowest cost silver QHP in Pennsylvania for 2014 plans ranged from $84.46 to $149.13.[4] Moreover, with the addition of cost-sharing, premiums plus cost-sharing under the ACA may be substantially more than 5% of household income, even with premium tax credits and cost-sharing reductions.[5] Focusing on the cost-sharing differential only, a study by Wakely Consulting Group in July 2014[6] concluded that the cost sharing (deductible, copays, and/or coinsurance) for a child on a silver plan, with cost sharing reduction subsidies, would be considerably more than the cost sharing for PA–CHIP coverage:

Income Level Coverage	160% FPL		210% FPL	
	PA–CHIP	QHP	PA–CHIP	QHP
Actuarial Value	100.0%	86%–88%	97.2%	72%–74%
Enrollee Average Percent of Allowed Claims	0.0%	12%–14%	2.8%	26%–28%
Average Annual Cost Sharing	$0	$411–$480	$98	$891–$960
Maximum Out of Pocket	$0	$500–$2,250	$1,419	$3,000–$5,200

This cost-sharing structure of PA–CHIP compares very favorably to QHP coverage available through the exchange. In many instances, cost-sharing for PA–CHIP enrollees will be equal to or less than a family would experience with enrollment in a QHP.

Benefits

PA–CHIP provides identical, comprehensive benefits to individuals enrolled in all levels of the program. Basic services include:

- Preventive care, including physician, nurse practitioner and physician assistant services;
- Specialist care, including physician, nurse practitioner and physician assistant services;
- Autism services, not to exceed $36,000 annual benefit cap (specified by Act 62 of 2008);
- Diagnosis and treatment of illness or injury;
- Laboratory/pathology testing;
- X-rays;
- Injections and medications;
- Emergency care, including emergency transportation;
- Prescription drugs;

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[4] *http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet_home.cfm.*

[5] *See, e.g., www.communitycatalyst.org/doc-store/.../affordability_in_aca.pdf; http://www.kaiserhealthnews.org/features/insuring-your-health/2013/070913-michelle-andrews-on-cost-sharing-subsidies.aspx.*

[6] "Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans," Wakely Consulting Group, July 2014 ("Wakely Study") available at *http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus-July-2014-.pdf.*

- Emergency, preventive and routine dental care, and medically necessary orthodontia;[7]
- Emergency, preventive and routine vision care;
- Emergency, preventive and routine hearing care; and
- Inpatient hospital care (90 days including mental health).

Additional medically necessary and therapeutic services include mental health services, inpatient and outpatient treatment of substance abuse, rehabilitative therapies, medical therapies, home health care, hospice care durable medical equipment, and maternity care.

Significantly, the Wakely Study distinguished child-specific benefits—those that are other than the core benefits typically included in a major medical insurance policy—and found that PA–CHIP covers 79% of those services, while QHPs cover only 50%. Child-specific benefits focus on dental, including orthodontics; vision; audiology; habilitation; and therapy coverages.[8]

PA–CHIP, like QHP coverage, includes some limitations on benefits. However, it is difficult to compare those limitations with the QHP coverage of those benefits for two reasons. First, QHPs may also impose limits, but data is not readily available to identify the frequency or level of those limitations, and the limits may vary by product and plan. Second, if a child is approaching those limits on PA–CHIP it is likely that the child will be eligible for Medicaid coverage through a special PA Medical Assistance program for children with special health care needs or chronic conditions (for which income is not considered when determining eligibility).

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

Federal funding for CHIP should absolutely be extended promptly. PA–CHIP has provided health care coverage to hundreds of thousands of children in Pennsylvania for over 20 years and is an example of how states can develop innovative solutions to meet the needs of their residents. Pennsylvania has worked tirelessly to continue providing PA–CHIP coverage as an option for children and their families. With the health care needs of Pennsylvanian's children at stake, it is critical that federal funding be extended to allow PA–CHIP as an option for families seeking coverage for their children.

Pennsylvania strongly recommends that federal funding be extended to align with Congress's authorization of the program, i.e. through fiscal year 2019. As current federal funding of CHIP is set to expire on October 1, 2015, Congress should begin the reauthorization process immediately. States, as partners in the CHIP program, need the timely assurance of funding as they prepare their budgets. But perhaps more critically, Congress should urgently address the continued appropriation of federal funding for CHIP to provide certainty for families who rely on CHIP coverage for their children.

In the absence of CHIP, families would have fewer options for accessing health care and more than 157,200 Pennsylvania children would need to find replacement coverage, which could take time, be more expensive, and potentially jeopardize the children's access to health care services. This would be devastating to Pennsylvania families.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

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[7] As a result of the CHIP Reauthorization Act of 2009 (CHIPRA), medically necessary orthodontia was added to the dental benefits package. The orthodontia benefit is capped at a lifetime maximum of $5,200. The yearly dental benefit limit is $1,500.

[8] See Wakely Study at Table 16, pages 26–27.

The states' allotments are based on complex methodologies specified in Section 2104(m) of the Social Security Act. Each state's federal fiscal year (FFY) allotment is adjusted based on several factors, including per capita health care growth and the child population growth.

For FFY13, ACA mandated a "rebasing" process to determine the allotment. This methodology bases the allotment on the states' payments (i.e., based on enrollment) rather than the allotments for FFY12. For FFY14, the methodology reverted to using the prior year allotments as a base. For FFY15, there will be two allotments: one for each six months of the FFY.

Pennsylvania has been fortunate since the passage of CHIPRA to have adequate federal funds to meet the increased demand for the CHIP services. We saw our CHIP enrollment increase from 183,000 to nearly 198,000 between early 2009 and mid-2010 before enrollment again leveled off and began a slow decline through 2012. The decline has continued due to the ACA requirement that children in the 100%–133% FPL range be enrolled in Medicaid, rather than CHIP.

The federal matching rate is set to increase by 23 percentage points beginning in FFY15. This will lead to a quicker exhaustion of federal CHIP dollars. Simultaneously, as Pennsylvania has experienced leaner enrollment figures—partially attributable to the unnecessary transfer of children to Medicaid—the formula works against Pennsylvania since the program's lower enrollment numbers will be used for calculating future allotments (rebasing). Thus, just as the matching rate is set to increase by 23 percentage points—resulting in a quicker exhaustion of federal CHIP funds—Pennsylvania will receive a smaller allotment of federal funds to support its CHIP program. Many states will be in a similar predicament.

In sum, it may be wise to take unspent funding from past years and make it available to states, such as Pennsylvania, that have decreased CHIP enrollment due to Medicaid expansion, so that their programs will not be doubly jeopardized when the significantly increased federal match funds are distributed in accord with the rebased allotments.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

When contemplating federal policies to reduce the number of uninsured children, Pennsylvania suggests a shift of focus away from only looking at the number of enrollees and move towards structuring programs that empower families to get engaged in improving their health and becoming more well-informed consumers of their health care. Focusing solely on the fluctuations in enrollment numbers distracts advocates, legislators, auditors, and others away from the overall goal of improving the health of children by ensuring there are a range of coverage options to allow a child to be covered, regardless of changing life circumstances. Under Governor Corbett's leadership, the health care coverage rate for children in Pennsylvania is close to 95%. While this is extremely high, Governor Corbett believes we can still do more and has pushed to continuously work toward getting all kids covered while also seeking to strategically improve Pennsylvania's overall health insurance system. Any policy changes contemplated by the federal government should align with Governor Corbett's *Healthy Pennsylvania* priorities: providing affordability, improving access, and ensuring quality.

Access to health care coverage must be affordable for consumers. To accomplish this, more incentives should be built into government programs to allow states to help individuals transition from fully subsidized coverage to self-sufficiency, such as additional premium assistance for employer-sponsored insurance. Policymakers should shift away from eliminating premiums, and rather toward giving states the flexibility to develop premium structures that are affordable for consumers and begin to build into these programs various levels of health care consumer engagement and a stronger focus on healthy behaviors. CHIP premiums are designed on a sliding scale based upon a family's ability to pay. As income increases, the cost-sharing rises closer to what is experienced in commercial health insurance coverage. The flexibility to stagger cost-sharing would allow the program time to engage consumers and begin educating enrollees on the benefits of having a personal stake in improving their health. Establishing greater flexibility could lead to the develop-

ment of healthy behavior incentive programs that reward good health care choices and improved health, therefore, allowing CHIP enrollees to receive some of the newest innovations in health care coverage that are found in the commercial health insurance market.

Access to health care coverage must also be available for consumers. Policymakers should focus on how to attract and retain highly qualified medical professionals as providers to facilitate better access to the health care system. As enrollment numbers increase, so potentially do the wait times to see a practitioner. When individuals desire to be in the medical profession, we should provide incentives to fill the gaps as far as medical specialties—including general practitioners—and geographic locations. As part of *Healthy Pennsylvania,* Governor Corbett continues to support loan forgiveness programs to incentivize primary health care providers to practice in rural and underserved areas of the Commonwealth.

Policymakers should seize the opportunity presented by the federal extension of CHIP to improve upon the program's strengths, and to allow CHIP to serve as an integral bridge to independence for CHIP children and their families.

State of Rhode Island and Providence Plantations

State House, Room 224
Providence, Rhode Island 02903
401–222–2080

Lincoln D. Chafee
Governor

October 28, 2014

Fred Upton, Chairman
House Committee on Energy and Commerce

Henry A. Waxman, Ranking Member
House Committee on Energy and Commerce

Ron Wyden, Chairman
Senate Finance Committee

Orrin G. Hatch, Ranking Member
Senate Finance Committee

Dear Chairmen and Ranking Members:

I appreciate the opportunity to express my strongest support for the continuation of the Children's Health Insurance Program (CHIP). The CHIP has been instrumental in reducing the number of uninsured children and pregnant women in Rhode Island and assuring they have access to the high quality prenatal and pediatric services they need to start and stay healthy. Moreover, the CHIP has provided Rhode Island with the crucial resources necessary to sustain RIte Care, the state's nationally recognized, successful Medicaid managed care program for families with children.

The significant contributions the CHIP has made to children's health are not unique to the State of Rhode Island. The CHIP has played a similar role in ensuring access to care and better health outcomes for children in states all across the nation. Given the gains the CHIP has made, it is critical that Congress act to re-authorize the program for an additional four more years along with the already scheduled 23 percent increase in the CHIP federal match rate. Without decisive action to extend the CHIP by the end of this year, millions of children will lose access to cost effective, high-value health coverage and we, as a nation, will be dealing with the consequences for generations to come. For states like Rhode Island which have emerged as leaders in children's health, the extension of the CHIP is critical not only for preserving the gains we have already made, but also for ensuring we have the resources necessary to continue to succeed in the years ahead.

As per your request, below are the responses to questions contained in your letter of inquiry pertaining to the scope and operations of the CHIP in Rhode Island:

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

Rhode Island operates a combined Medicaid/CHIP program for families, pregnant women, and children through its RIte Care managed care delivery system. RIte Care uses a medical home model centered on providing the best evidenced-based practices in primary care.

As of September 30, 2014, an average of 20,803 of the children and pregnant women enrolled in RIte Care received health coverage funded, in whole or in part, by the CHIP. As we administer a joint Medicaid/CHIP program, we use a single income eligibility for each RIte Care population regardless of funding source. The Modified Adjusted Gross Income (MAGI) eligibility limit for RIte Care children is at or below 261% of the federal poverty level (FPL); the MAGI limit for pregnant women is at or below 253% of the FPL.

Since RIte Care was established 30 years ago, we have been providing high-quality, affordable health care to Rhode Islanders who might otherwise be uninsured. The CHIP has enabled Rhode Island to maintain and, in some instances, expand RIte Care eligibility for children and pregnant women at risk for poor health outcomes from regions all across the state. On-going evaluations of RIte Care health plans show that they are achieving positive health and utilization outcomes ranging from low rates of emergency hospital admissions and preventable hospitalizations, to fewer high-risk pregnancies and infant deaths, declines in pregnant women who smoke and present with gestational diabetes, and healthier newborns, infants, and children overall.

Rhode Island has one of the lowest rates of uninsured children in the country (5.4% of children lacked insurance coverage in 2013). This low rate of uninsured children is due, in a large part, to Medicaid/CHIP-funded RIte Care coverage. Rhode Island's CHIP participation rate was 90.4% in 2012, higher than the national average of 88.1%. However, Rhode Island still has room to improve. Approximately 71% of the uninsured children in Rhode Island between 2010 and 2012 were eligible for RIte Care based on their family income, but were not enrolled. While some of these children mostly likely enrolled in 2014, we know that we still have uninsured children in the community and CHIP is key to helping us to finish the job of insuring kids.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

There have been several changes made to the RI CHIP as a result of the Patient Protection and Affordable Care Act (PPACA). Each is outlined below:

CHIP Claiming—A major impact of the PPACA was the loss of the state's authority to claim CHIP funds for health coverage provided to RIte Care families with incomes under 133% FPL. The loss of revenue from that change forced the state, for financial reasons, to lower the Medicaid/CHIP eligibility of parents and caretakers from 175% to 133% of the FPL and shift them to our new health insurance marketplace—HealthSource RI (HSRI). The state has offered these parents state-funded premium assistance to help pay for the federally subsidized qualified health plans (QHP) they can now purchase through HSRI.

MAGI Income Standard—The PPACA required all states to use the MAGI methodology for determining income eligibility for Medicaid and CHIP coverage. Beginning in 2014, Rhode Island eligibility levels for the CHIP were revised upwards by 3 to 5% based on MAGI methodology.

Streamlined Access—The PPACA required states to simplify the application process, coordinate enrollment between Medicaid/CHIP and QHP coverage, and implement an electronic verification process to ensure seamless access to coverage options. Rhode Island has made significant progress in improving access in all these areas through our new automated eligibility system. We now have a fully integrated and interoperable system which uses a single on-line application for making determinations for affordable coverage funded wholly or partially through Medicaid/CHIP, federal tax credits and cost sharing reductions, or employers.

Consumer Support—Rhode Island implemented enhanced consumer support services as required by the PPACA in October of 2013. Implementation of these new services in conjunction with our new unified eligibility greatly improved RIte Care access and enrollment. For example, from October 2013 to March 2014, an additional 12,000 children and parents with CHIP-funded coverage enrolled in RIte Care managed care plans.

Elimination of Premiums—The coordination between Medicaid/CHIP and QHP plans required by the PPACA posed operational and equity issues for continuing

RIte Care premiums. The state opted to eliminate RIte Care premiums effective January 1, 2014 to: (1) reduce the likelihood of premium stacking; and (2) provide an incentives for parents of RIte Care eligible children to enroll in a QHP through HSIU if otherwise not qualified for Medicaid coverage.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost-sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

At present, there are no commercial QHPs available in Rhode Island that provide health care coverage comparable to the Medicaid/CHIP-funded RIte Care plans when taking into account differences in the scope, amount, and duration of benefits and cost-sharing obligations. RIte Care enrollees have no cost-sharing or out-of-pocket costs. Additionally, RIte Care plans provide a more extensive array of child-specific services with fewer limits than QHPs. For many families, especially those who have a child with disabilities, it is nearly impossible to obtain comparable coverage to RIte Care plans at an affordable cost even through subsidized HSRI plans.

There are two areas of coverage where the differences between RIte Care and QHP plans is most pronounced due in large pan to federal Medicaid and/or CHIP requirements: RIte Care enrollees must have access to comprehensive pediatric dental coverage and any medically necessary services deemed warranted as a result of Early Periodic Screening Detection and Treatment (EPSDT) requirements. In Rhode Island, as in most states, pediatric dental coverage and many EPSDT services are either unavailable or unaffordable in the commercial health insurance marketplaces. We do not anticipate that commercial or employer-sponsored plans will provide coverage for these services for children in the near future: most enrollees in these plans purchase them out-of-pocket.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

As stated at the outset of this letter, Rhode Island strongly supports extending CHIP's funding and as soon as possible. The state is facing significant budget pressures in the year ahead and most likely will be unable to sustain Medicaid coverage at current eligibility levels for certain populations if the CHIP is not re-authorized. The sooner Congress passes legislation to extend CHIP funding, the less uncertainty there will be and the more time states will have to ensure critical coverage is not disrupted. Congress should also maintain the scheduled 23 percent federal matching rate increase that goes into effect next year. These enhanced matching funds will help states like Rhode Island continue to provide high quality children's health coverage, as they have since the CHIP was initially enacted. Rhode Island also recommends that Congress extend CHIP funding at least through 2019. The PPACA requires states to maintain current Medicaid and CHIP eligibility levels for children until 2019. This Maintenance of Effort (MOE) provision would apply to the nearly 20,000 RIte Care children currently funded through CHIP.

If CHIP funding is not renewed, Rhode Island would lose the enhanced CHIP match but still be required to maintain existing coverage levels at the lower Medicaid FMAP under the MOE. As a result, Rhode Island's federal financial support for coverage would decrease by the difference between the CHIP and Medicaid match rates. For FY2014, Rhode Island's CHIP–FMAP is 65.08 percent. The scheduled match increase would bring Rhode Island's CHIP–FMAP to 88.08 percent. In comparison, Rhode Island's FMAP for FY2014 is 50.11 percent.

It is essential that Congress act to reauthorize the CHIP in a timely manner that takes into consideration the imperatives of state budget cycles. If Congress delays taking action until FY2016, states like Rhode Island face dire fiscal consequences: Rhode Island stands to lose an estimated $28.19 million of annual federal CHIP dollars. Covering any of this difference would be a challenge for our state, given current and projected deficits. As roll-backs in eligibility for children are not feasible, Rhode Island will have no option but to reduce access to Medicaid coverage for adults, vulnerable elders and persons with disabilities, most of whom will be unable to purchase comparable affordable coverage through HSRI.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

The CHIP allotment for Rhode Island has not been sufficient. We are among the states that regularly exhaust our CHIP allotment and receive additional dollars (a total of millions) from other states that have not done so. Although no new federal funds for allotments are slated for FY2016, Rhode Island will continue to be able to draw on unspent federal CHIP funds returned by other states, as long as they are available, unless Congress develops a new allotment formula. Congress may want to consider the option of increasing allotments to states like Rhode Island which not only consistently use their complete allotment, but achieve improvements in health access and outcomes that meet or exceed the goals of the CHIP.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?

Although Rhode Island has had some success on the enrollment front, we are committed to providing every child in the state with access to high quality health care. There are several strategies and federal policies that could be implemented to facilitate access and improve health outcomes. For example, Congress could allocate more resources to expand services in high demand, such as pediatric dental coverage, by providing an enhanced federal match.

Congress may also want to consider providing states like Rhode Island that operate combined Medicaid/CHIP programs and/or utilize their full allotments with additional flexibility. Combined programs are bound to follow Medicaid rules and this prevents states from using the flexibility provided in the CHIP authorizing statute to tailor benefit packages to meet the changing needs of the children we enroll. In Rhode Island, additional flexibility would allow us to focus on high demand but short supply service areas like behavioral health and to develop new design, delivery and payment approaches that more effectively leverage and integrate federal and state dollars, promote population health, and recognize the whole range of social supports kids need to start and stay healthy—e.g., stable families, housing, food security, etc.

Conclusion

I urge you to extend CHIP funding as soon as possible. CHIP is essential to assuring that we do not lose ground on children's coverage in Rhode Island and as a nation.

Thank you for the opportunity to respond to these important questions. Please contact me or any member of my staff should you have any questions.

Sincerely,

Lincoln D. Chafee
Governor, State of Rhode Island

cc: Steven Costantino, Secretary, Executive Office of Health and Human Services
David Burnett, Deputy Director, Executive Office of Health and Human Services
Deidre Gifford, Medicaid Director, Executive Office of Health and Human Services
Deborah Florio, CHIP Director, Executive Office of Health and Human Services
Jacqueline Kelley, Esquire, Executive Office of Health and Human Services

STATE OF SOUTH DAKOTA

DENNIS DAUGAARD, GOVERNOR

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October 28, 2014

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Upton,

Thank you for the opportunity to provide information about the Children's Health Insurance Program (CHIP) reauthorization. CHIP provides insurance coverage to over 12,500 low-income children in South Dakota, and I strongly support continued funding for this program.

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state?

   There were 12,519 children enrolled in the CHIP program during our State Fiscal Year 2014 (July 1, 2013–June 30, 2014). Eighty percent of the children are age six years or older. The vast majority of children are at lower incomes with 77%, with income less than 182% of the federal poverty level ($43,407 annually for a family of four).

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act (PPACA)? How has the implementation of PPACA impacted the way your state administers CHIP?

   South Dakota implemented the required PPACA changes including the federal poverty level conversion, modified adjusted gross income (MAGI) eligibility methodologies, use of the federally required streamlined application to include tax filer information for other Insurance Affordability programs and Qualified Health Plans, and telephonic application capability. Although CHIP funding expires in September 30, 2015, the CHIP program remains authorized and states may use unspent portions of their FFY15 allotments. In addition, the PPACA also increased the enhanced Federal Medical Assistance Percentage (FMAP) available to states for CHIP programs by 23% beginning in FFY16. Unless CHIP allotments are increased, this will speed up the rate at which states spend their allotments resulting in potential funding shortfalls. The PPACA also added a Maintenance of Effort (MOE) provision and states must maintain Medicaid and CHIP eligibility standards, methodologies, and procedures that are no more restrictive than those in effect March 23, 2010. An exception to the MOE requirement includes the lack of federal CHIP funding.

   Despite these changes, the Centers for Medicare and Medicaid Services (CMS) maintain the implementation of PPACA would not result in significant reductions to the CHIP program. However, South Dakota continues to experience a significant shift of children from the CHIP program where services are paid at the enhanced federal match rate to Medicaid where services are funded at the regular Federal Medical Assistance Percentage (FMAP). From December 2013 to August 2014, we saw a decrease of 1,833 children (–13.4%) in the CHIP program. During this same time period, our Title XIX children have increased by 2,647 (4.1%). This is the opposite trend we saw in the six months prior to PPACA implementation. From June 2013 to November 2013, we saw an increase of 604 (4.6%) CHIP recipients while our Title XIX children recipients were decreasing by 1,414 recipients (–2.1%).

   South Dakota expressed concern with CMS in March 2013 when the poverty level conversions were first provided. We began to see a significant reduction to our CHIP program in January 2014 when the new federal poverty levels were implemented. At the end of April, we saw 19% fewer children enrolled in the CHIP program and an offsetting increase to children enrolled in Medicaid. In April, after continued discussions with CMS, CMS agreed to adjust the federal poverty levels by approximately 30%. While we were pleased with this adjustment, we continue to see a shift from CHIP to Medicaid for children.

Our latest numbers through August 2014, after adjusting the federal poverty levels, reflect a 13.5% reduction in CHIP enrollment. The result is a cost shift from the federal government to our state. In addition, although the state has successfully been able to send and receive applications to and from the Federally Facilitated Marketplace (FFM), the FFM is unable to check for existing Medicaid/CHIP eligibility causing applications to be sent to the state to process even though the applicant is already eligible for Medicaid/CHIP. Significant administrative effort was expended in assisting individuals and families who were "stuck" in the FFM process. The MAGI methodologies, while simplified, also require increased effort to determine eligibility individually rather than a single determination per household. The PPACA related federal reporting requirements are yet to be determined.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

South Dakota operates CHIP as a Medicaid look-alike program, where all Medicaid benefits are extended to individuals eligible for CHIP. In addition to the essential health benefit offered through the marketplace plans, children eligible for CHIP have access to the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) benefit. The EPSDT benefit allows South Dakota to provide medically necessary services to children outside of the scope of the normal services under the Medicaid or CHIP State Plan and those offered through the marketplace plans. No similar benefit is available from private health plans where children are only eligible to receive services within the limits imposed by the plan.

Some of the children who would lose coverage if CHIP is not funded will not be eligible for tax credits through the federal marketplace because a parent may have access to employer sponsored coverage. However, the affordability test for employer coverage is based on a calculation of the individual coverage relative to a workers wages, not the cost of a family policy. This situation is referred to as the "family glitch" and could leave more children uninsured.

While families at or above 100% Federal Poverty Level (FPL) are eligible to apply for subsidies and enroll in health plans offered through the exchange, the cost sharing, premiums, and out of pocket costs for plans available through the marketplace are at levels most low-income families on the CHIP program cannot afford. For example, a family at 183% FPL ($43,656 annually for a family of four) would be eligible to apply for the average silver plan through the marketplace at an average net monthy cost after subsidy of $174 per month. Additional premiums ranging from $6 up to $38 per dependent would apply and the out of pocket costs for the family plan would double from $2,750 to $5,500 by adding additional dependents. In addition, if CHIP were eliminated, parents with employer sponsored health insurance with a cost under 9.5% of their income would not be eligible for subsidy and would bear the full cost of the premium. Because families are not required to pay a premium for CHIP coverage and children under age 21 in South Dakota are exempt from cost sharing, these increased costs may result in reduced access to essential healthcare services for children. Preventative care, including preventive oral health care has direct impacts on longer term health and avoiding higher cost care.

4. Do you recommend that CHIP funding be extended? It so, for how long, and for budgeting and planning purposes under what timeframe should Congress act upon an extension? If you do not believe CHIP should be extended, what coverage, lf any, do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

We recommend that the CHIP funding be extended indefinitely and Congress should act on the extension of the CHIP as soon as possible to ensure there are no gaps in federal funding for the program. The South Dakota legislature will act on my fiscal year 2016 recommended budget in March of 2015. The status of South Dakota's current $20.0 million dollar federal CHIP award is a critical component of our Medicaid budget. Currently, South Dakota utilizes CHIP funding for Medicaid eligible children who are uninsured and whose income is between 111% and 182% of the federal poverty level (over 9,200 chil-

dren). If CHIP funding ends, South Dakota will be required to cover these children at the regular FMAP rate at an additional cost of $3.0 million in state funds due. South Dakota also utilizes CHIP funding for uninsured children whose family income is between 182% FPL and 204% FPL (over 2,660 children). If CHIP funding ends, these children will lose coverage altogether as there is no Medicaid coverage group for them.

In addition to funding benefits, CHIP is used to fund $1.0 million annually in administrative costs, primarily for program eligibility determination staff. The loss of CHIP funding would result in an annual state general fund impact of $160,000.

5. In spite of restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

   The redistribution of CHIP funding in 2009 was critical for South Dakota. Prior to the redistribution, South Dakota1s annual expenditures for children eligible for CHIP exceeded our CHIP allotment. The redistribution increased our allotment by $10.0 million, which aligned our award closer to our annual expenditures for children eligible for CHIP, avoiding a budget impact to the state or reducing eligibility levels for the program. The enhanced FMAP rates of 23% for CHIP under the PPACA will provide state general fund savings. However, if CHIP allotments are not increased, South Dakota will not have adequate CHIP federal funds to support annual expenditures, resulting in a shift of children to the Medicaid program at the regular FMAP rate. Congress should adjust CHIP federal allotments commensurate with the 23% enhanced matching rate for CHIP.

6. Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job of enrolling eligible children?

   South Dakota has a high penetration rate relative to CHIP and Medicaid coverage for children. Continued funding for the CHIP program offers a strong financial incentive for continued efforts to enroll children where services will be paid at a match rate almost 15% higher than South Dakota's regular FMAP rate.

7. What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?

   The ability of the Federally Facilitated Marketplace (FFM) to verify Medicaid and CHIP eligibility must be resolved to avoid children being "stuck" in the FFM process and unnecessary duplication of effort by state resources.

I encourage Congress to act quickly to appropriate funding for the CHIP program so that low-income children in South Dakota continue to have insurance coverage.

Sincerely,

Dennis Daugaard

State of Tennessee

Bill Haslam

GOVERNOR

State Capitol • Nashville, TN 37243–0001 • PH: 615–714–2001 • www.tn.gov

October 31, 2014

The Honorable Fred Upton
Chairman
U.S. House of Representatives
Committee on Energy and Commerce
2125 Rayburn Office Building

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building

Washington, DC 20515

The Honorable Henry A. Waxman
Ranking Member
U.S. House of Representatives
Committee on Energy and Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Washington, DC 20510

The Honorable Orrin G. Hatch
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Upton, Ranking Member Waxman, Chairman Wyden, Ranking Member Hatch:

The purpose of this letter is to respond to your questions regarding the reauthorization of the Children's Health Insurance Program (CHIP), for which funding ends at the end of Fiscal Year (FY) 2015.

CHIP is a successful program providing healthcare coverage for children, but as a result of the PPACA, CHIP reauthorization must now be considered carefully within the context of overlapping, government-subsidized healthcare coverage programs. The PPACA has increased health care coverage silos, which reduce efficiency, increase member churning across arbitrary eligibility boundaries, and cause families to be split across different plans due to the eligibility status of individual family members.

Tennessee is looking for opportunities to streamline and simplify eligibility. I believe children covered by the CHIP program will have access to alternative coverage options that offer comparable services in the future. However, I do not believe that there is enough time to adequately consider and implement policy changes before federal funding for the CHIP program ends next year. Therefore, I recommend CHIP financing be extended for at least two years, through Federal FY 2017. In addition, states' maintenance of effort requirement, currently in effect through September 30, 2019, should end if the current level of federal participation in CHIP ends.

Below are detailed responses to your July 29, 2014 letter regarding Tennessee's experiences with the CHIP program.

Sincerely,

Bill Haslam
Governor

cc: Darin Gordon, Deputy Commissioner, Department of Finance and Administration
Brooks Daverman, Director of Strategic Planning and Innovation

1. **How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g., income, health status, demographics)?**

   Tennessee's CHIP program is a "Combination" program with two components that provide coverage to approximately 88,000 children using Title XXI funds.

   Approximately 68,000 children are covered through Tennessee's stand-alone CHIP program called CoverKids. Of these, about 45 percent are below 150 percent FPL, 38 percent are between 150 and 200 percent FPL, and 18 percent are between 200 and 250 percent FPL. Over three-fourths of children in the CoverKids program are between the ages of 6 and 18. Less than 5 percent are unborn children.

   Approximately 20,000 CHIP enrollees are served through the TennCare program. Nearly 9 out of 10 children in this group have incomes below 150 percent of the FPL. Over three fourths are between the ages of 6 and 18. About 70 percent are White, while 13 percent are Hispanic and 12 percent are Black/African American.

2. **What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?**

   Tennessee has made a number of changes to its CHIP program as the result of the PPACA. These include the following;

- Tennessee eliminated our state-funded "buy in" CHIP eligibility category for families over 250 percent of the federal poverty level as of January 1, 2014. This category included children with family incomes above the maximum set by CHIP in Tennessee. With the availability of subsidized insurance through the federal Marketplace, the state no longer needed to subsidize the coverage of children who were above the income level for CHIP in Tennessee.
- Tennessee eliminated the three month "go bare" period, requiring children to be uninsured for three months before becoming eligible for CHIP. As a result of the PPACA's guaranteed issue requirement, this policy was no longer relevant.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and/or benefits and/or cost-sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

While we do not have a detailed comparison of benefits for any particular plan, we know that the benefits offered by our CHIP program are roughly comparable to those offered by Qualified Health Plans (QHPs) in the federal Market place. However, cost sharing is lower in CHIP than in most, if not all, QHPs currently offered in the Marketplace. There are no premiums or deductibles required of CHIP children, as there are of individuals enrolled in a QHP, and CHIP copays are relatively modest. The actuarial value of Tennessee's CHIP plan is between 90 and 95 percent which is slightly higher than a platinum level plan available in the Marketplace.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeline should Congress act upon an extension? If you do not believe that CHIP funding should be extended, what coverage: (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

We recommend that CHIP financing be extended for at least two years until alternative policy options can be fully considered. One alternative for CHIP enrollees is subsidized coverage available through the federal Marketplace. Certain policy changes will need to take place before states can move freely in this direction.

Currently the rules of the Department of the Treasury do not allow the children of an employee to access the federal Advanced Premium Tax Credits if the employee is offered affordable employer-sponsored health insurance. However, the affordability test does not take into consideration the cost of family coverage, only individual coverage. Tennessee will be unable to support covering currently CHIP-eligible children through the federal Marketplace until the Department of the Treasury issues an update to the Health Insurance Premium Tax Credit final rule (2012) so that children can be eligible for federal premium assistance tax credits in families where affordable employer-sponsored coverage is available for only the employee.[1] A change to this rule would allow more families to stay on the same plan and receive subsidized private coverage through the federal Marketplace. We believe the Health Insurance Premium Tax Credit rule should be updated before funding for CHIP ends.

In addition, the PPACA's maintenance of effort requirement on states for their CHIP program needs to be modified to reflect any changes to the program. As long as the maintenance of effort requirement remains part of federal law, we cannot consider any changes that affect CHIP.[2] After these changes are made, states will be able to further consider policy options regarding the CHIP program.

If comparable, affordable QHP coverage is available for families in the Marketplace, we believe that the QHP coverage should be considered as a potential coverage option for uninsured children in the state if CHIP were not continued.

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[1] 26 CFR § 1.36B–2(c)(3)(v)(A)(2), *Eligibility for premium tax credit,* Federal Register Vol. 77, no. 100, *http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/FR-2012-05-23.pdf.*

[2] PPACA; Public Law 11–148; 2101(b), *Additional federal financial participation for CHIP.*

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

We believe Tennessee's federal allotment for CHIP will be sufficient for FY 2015.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?

We believe that federal policies should be targeted to streamlining and simplifying the eligibility policies of various programs. CHIP, Medicaid, and the Health Insurance Marketplaces have been layered on top of each other, creating duplicative coverage silos, each with their own benefit and eligibility rules. Duplication of programs reduces efficiency, increases member confusion, and causes beneficiaries' to "churn" across arbitrary eligibility boundaries as their age and income change. Many families are now split among coverage programs, such as families with children in CHIP and adults covered on the Marketplace. In order to be more customer-focused and relevant to meeting the needs of low-income families, federal health policy and program eligibility must be simplified.

The State of Texas

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Rick Perry
Governor

October 31, 2014

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The Honorable Henry A. Waxman
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The Honorable Ron Wyden
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The Honorable Orrin G. Hatch
Ranking Member
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Committee on Finance
104 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairmen Upton and Wyden and Ranking Members Waxman and Hatch:

I appreciate the opportunity to provide Congress with feedback regarding the Children's Health Insurance Program (CHIP), which provides health insurance coverage for certain uninsured children. States possess valuable insights on the efficacy and efficiency of CHIP given that they implement the program and see firsthand the impact of the Affordable Care Act (Obamacare).

The Texas Legislature passed legislation in 1999 creating CHIP, separate from Medicaid. Texas provides services for children of families with income at or below 200 percent of federal poverty level (FPL). Figures provided by the Texas Health and Human Services commission (HHSC) show that in FY 2014, Texas CHIP served 524,658 children. Of that:

- 60.9 percent of recipients are ages 6–14;

- 22.3 percent are ages 15–18;
- 16.7 percent are ages 1–5; and
- 0.1 percent of recipients are younger than one.

In terms of income in FY14:

- 55.9 percent have incomes between 100–150 percent FPL;
- 30.9 percent have incomes between 151–185 percent FPL;
- 6.7 percent have incomes between 186–200 percent FPL; and
- 6.5 percent of recipients have incomes below 100 percent FPL.

Texas CHIP provides a variety of services to its recipients, including preventive health, dental, vision, mental health and hospital services. Texas requires certain CHIP families to pay an annual enrollment fee to cover all children in the family. Qualifying families must also pay co-pays for doctor visits, prescription medications, inpatient hospital services and non-emergent services in an emergency room setting. Additional information can be found here:*http://www.hhsc.state.tx.us/medicaid/about/PB/10_PB_9th_ed_Chapter9.pdf.*

As a consequence of Obamacare, Texas has seen a significant number of children moved from CHIP into Medicaid. Though Obamacare provides for enhanced matching rate for this CHIP-to-Medicaid population, these enhanced federal funds diminish over time—shifting costs to the states.

Moving additional people into Medicaid is particularly significant given that Obamacare exacerbates problems with a broken Medicaid program. For example, Obamacare prevents states from using common-sense tools, including asset testing, to ensure that Medicaid is preserved for those individuals most in need. Furthermore, Obamacare taxes Medicaid to help fund private insurance subsidies for individuals who earn more than Medicaid recipients. In other words, Obamacare makes it more expensive for both federal and state governments—and ultimately the American taxpayer—to operate Medicaid, providing absolutely no benefit to the program or its recipients. As I explained in a recent letter to Congressman Elijah Cummings, current state and federal Medicaid expenditures are unsustainable. Obamacare only compounds that problem.

Additionally it's important to point out characteristics of CHIP that differentiate the program—for the better—from Medicaid. For example, states receive federal matching funds for CHIP through allocations that function in a manner very similar to block grants. States have considerably more flexibility in operating their CHIP programs than Medicaid programs. Such flexibility empowers states to better serve their unique CHIP populations. States have the ability to implement reasonable cost-sharing and enrollment measures that help ensure appropriate utilization of services, emphasize preventive care and encourage active participation in health care decisions.

Absent much needed comprehensive Medicaid reform, Congress should implement in Medicaid those initiatives that have proven to be effective and beneficial to CHIP and recipients.

As for the reauthorization of CHIP, given that there appears to be no immediately viable alternative proposed for covering existing CHIP recipients, Congress should act to reauthorize CHIP prior to the expiration of funding in 2015. The sooner action is taken, the more predictability and stability Congress will provide to state appropriators.

Please do not hesitate to contact my office or HHSC for any additional information.

Sincerely,

Rick Perry
Governor

State of Utah

OFFICE OF THE GOVERNOR
Salt Lake City, Utah
84114–2220

GARY R. HERBERT
GOVERNOR

SPENCER J. COX
LIEUTENANT GOVERNOR

November 5, 2014

The Honorable Fred Upton
Chairman
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The Honorable Ron Wyden
Chairman
Committee on Finance
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Washington, D.C. 20510

The Honorable Henry A. Waxman
Ranking Member
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Washington, D.C. 20515

The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
U.S. Senate
Washington, D.C. 20510

Dear Chairman Upton, Chairman Wyden, Representative Waxman, and Senator Hatch:

I am grateful for the opportunity to provide you with feedback regarding Utah's position on funding for the Children's Health Insurance Program (CHIP). The bottom line is that the CHIP has decreased the number of uninsured children in our state and that there remains a need for the CHIP until low income working families have a viable alternative to providing care for their children. Furthermore, Americans would be well-served by a federal government that provides maximum flexibility to states to provide services to their residents in the most efficient and effective ways possible.

In an attempt to be responsive to your inquiry, I have asked Michael Hales, director of Medicaid and Health Financing in Utah, to answer your specific questions on our state's behalf. His response is attached.

Thank you for your attention to this important matter. We appreciate your outreach on the CHIP and any other issues that have a substantial impact on Utah.

Sincerely,

Gary R. Herbert
Governor

Utah Department of Health

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W. David Patton, Ph.D.
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

November 5, 2014

The Honorable Fred Upton
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The Honorable Ron Wyden
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The Honorable Orrin G. Hatch
Ranking Member
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Washington, D.C. 20510

Dear Chairman Upton, Chairman Wyden, Representative Waxman, and Senator Hatch:

At the request of Governor Herbert, Utah's CHIP team has compiled the following information. We hope you find it responsive to your inquiries. We stand ready to provide any additional information that you may need. Thank you for your outreach and consideration of Utah's experience.

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

Utah's Response: The implementation of PPACA had a significant impact on the CHIP in Utah. Utah was one of three states in the nation, which had an asset test for Medicaid eligibility for children ages 6–18 prior to 2014. PPACA not only raised the eligibility income level for Medicaid children but also required the elimination of any asset test for Medicaid children. Prior to the implementation of PPACA, Utah averaged about 34,000 children per month on CHIP. With the implementation of PPACA, the number of children on Utah's CHIP has dropped to an average of 15,000 per month and it continues to be an important program for the children of Utah.

Before implementation of PPACA, children with household incomes from 0 to 200 percent of the federal poverty level (FPL) could be eligible for Utah CHIP. The program was broken out into three plans: Plan A for family incomes between 0–100 percent FPL, Plan B for family incomes between 101–150 percent FPL, and Plan C for family incomes between 151–200 percent FPL. Plan A existed primarily because Utah had an asset test for Medicaid children ages 6 to 18, but did not have an asset test for CHIP. Consequently, children ages 6 to 18 with family incomes under the poverty level enrolled in CHIP, rather than Medicaid. It was not uncommon to have younger children (under age 6) on Medicaid and older children on CHIP in a single household. Since the implementation of PPACA earlier this year, Utah CHIP eligibility covers children in families whose income is between 133 percent FPL and 200 percent FPL. CHIP Plan A was eliminated—leaving a modified Plan B (133–150 percent FPL) and Plan C (151–200 percent FPL).

The majority of CHIP families have earned income. Children in these families are eligible for CHIP either because they have no health insurance coverage available through an employer or because the costs of the employee's share of coverage is unaffordable. Utah's CHIP applies a test of five percent of gross annual income to determine if the cost of coverage is reasonable.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

Utah's Response: As indicated above, PPACA changed the eligibility income levels for Medicaid and removed the asset test for children. This resulted in a significant reduction in the number of children on the stand-alone CHIP in Utah. However, since the children who transferred from CHIP to Medicaid are still eligible for the enhanced FMAP available under CHIP, Utah has had to implement a more complex expenditure tracking model to claim the enhanced FMAP on the CHIP children who transferred to Medicaid. The implementation of PPACA required significant changes in eligibility requirements for both Medicaid and CHIP, taking away much of the flexibility Utah previously had in determining eligibility for CHIP. With regard to benefits and service delivery, Utah's process remains largely unchanged.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and/or benefits and cost sharing provided in your state under CHIP that are not comparably available through your state's exchange or the majority of employer sponsored health plans in your state.

Utah's Response: By state law, Utah's CHIP benefit is benchmarked against the HMO with the largest commercial, non-Medicaid enrollment in the state. Therefore, the benefits available to Utah CHIP children are very much like benefits offered in a silver plan available in the commercial market with a couple of exceptions. Utah does not operate an individual plan exchange. Utah has an agreement with the federal government to operate a federally facilitated exchange for the private individual market in our state. In addition, Utah operates a small employer exchange, known as "Avenue H."

As a stand-alone program, CHIP cost sharing includes co-payments, coinsurance, and premiums and is limited to five percent of the family's annual gross income. Cost-sharing reductions for families on the exchange are limited to 94 percent actu-

arial value (AV) for 100–150 percent FPL and 87 percent AV for 150–200 percent FPL. Even though the cost-sharing reductions create a plan that limits *average* out of pocket costs, the costs facing a family with a severe medical issue could easily exceed the CHIP five percent of income standard. If CHIP is eliminated, CHIP families will experience greater out-of-pocket costs in the marketplace.

Second, a significant number of Utah CHIP families work for small employers. Under PPACA, if the employee's share of premium for the employee's coverage (not family coverage) is less than 9.5 percent of the annual gross household income, the family is not eligible for advanced premium tax credits to purchase private coverage instead of getting coverage at work. This issue is commonly known as the "family glitch." If CHIP is no longer available, former Utah CHIP families will be subject to higher cost sharing, and many will likely not be eligible for tax credits to help defray the cost of family coverage.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

Utah's Response: Any change to the existing CHIP will impact Utah's budget for state fiscal year 2016. State appropriations for this period will be determined by mid-March 2015. Therefore, it is imperative that Congress act soon to make a decision on this issue. Thousands of Utah children will be impacted. Utah and other states cannot wait until the last minute to transition these families or make substantive changes to Utah CHIP and the data systems that support this program. As mentioned earlier, Utah administers benefits for CHIP through contracts with private entities that will also be significantly impacted by any change. Most importantly, Utah children with chronic or emergent conditions could go without care because of a lack of action on this issue.

At a minimum, states must know whether or not the CHIP will continue, and whether or not changes will be made to the program or funding for the program at least six months in advance of any change. That being said, Utah supports extending the CHIP for at least two years, and preferably for four years, to allow time to address any outstanding issues with the federal market place and the availability of subsidies. In addition, other changes should be made to federal law to address state concerns.

Utah has identified the following issues of concern that need to be addressed in the CHIP:

1. Continuing issues with the Healthcare.gov web site and remaining issues with the interface between the federal government and the state need resolution.
2. Federal law should be changed to resolve the "family glitch."
3. The CHIP needs ongoing funding, or the federal law regarding the Maintenance of Effort (MOE) must be modified to delink the CHIP from Medicaid and provide states with flexibility on this issue.
4. Federal law should allow states to use the commercial market with the assistance of premium subsidies as the primary service delivery system for the CHIP.

Utah continues to have approximately 55,000 uninsured children, who appear to be eligible for public programs based on their income. It is difficult to determine exactly why these children remain uninsured. Some parents choose not to access public programs. Many do not seek coverage while their children are healthy. Others may be children of mixed immigration status households, which hesitate to seek assistance for other reasons. If the CHIP is eliminated, Utah anticipates the number of uninsured children in the state will increase.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

Utah's Response: Utah has no concerns with the CHIP allotments or the formula used to determine those amounts. We have been able to manage our program effectively under the current allotment formula.

6. Over the past number of years, states have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured and improve the health outcomes for children in your state?

Utah's Response: We recognize that many changes were made in an effort to streamline eligibility for Medicaid and the CHIP. PPACA also intended to make the commercial market place more accessible to all. Unfortunately, many of the changes brought about by PPACA did anything but simplify the enrollment process. A part of the concern is the prescriptive nature of the law and the lack of flexibility for states. The issues with the federal marketplace are also well known.

In addition, there needs to be a more seamless way to address churn for lower income families. Relatively small, but often frequent, changes in income can cause these families to move from the market place to public programs and back again. Utah would like to see more flexibility in the CHIP to allow broad use of Title XXI funding to provide premium subsidies to families to keep them in the commercial marketplace, even when their income drops to CHIP income eligibility level. This not only allows families to stay in the same health plan together but it also allows families to stay with the same provider network, which minimizes disruption in services and promotes continuity of care.

It is imperative that Congress act quickly but thoughtfully on the determination of the future of the Children's Health Insurance Program. Thank you for consideration of our input. We look forward to continued dialogue on this issue.

Sincerely,

Michael Hales
Deputy Director, Department of Health
Director Medicaid and Health Financing

PETER SHUMLIN
GOVERNOR

State of Vermont

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October 14, 2014

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RE: Children's Health Insurance Program (CHIP)—Vermont

Dear Chairmen and Ranking Members:

In response to your recent inquiry, I have asked my Vermont Agency of Human Services to compile answers to your six questions regarding the Children's Health Insurance Program (CHIP), including an assessment of impact should federal fund-

ing for the program end at the close of the 2015 federal fiscal year. We appreciate the opportunity to provide Vermont's perspective. Please find our responses below.

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

   Vermont has a longstanding commitment to providing coverage for all children. In Vermont, CHIP is operated as part of Dr. Dynasaur, the umbrella name for state sponsored children's health insurance, which includes Medicaid and CHIP. In 1989, Dr. Dynasaur was created as a state-funded program that extended coverage for children under age 7 to 225% FPL. In 1992, coverage was expanded to children up to age 18.

   In 2013, CHIP served 7,393 children ages 0–19, with a family income between 237% and 312% of federal poverty level. Vermont is a rural state with 67% of the population living in rural areas. In the most rural areas of the state over 60% of the population is eligible for Medicaid. Vermont's population is 97% white, with 3% from a variety of racial and ethnic backgrounds.

   The 2012 Vermont Household Health Insurance Survey reported that 51.0% of Vermont's 111,257 children under 18 had private insurance, 43.4% had coverage through Dr. Dynasaur (Medicaid/CHIP), and 2.5% were uninsured. The rate of uninsured children has steadily declined from 4.9% in 2005. Between December of 2013 and April of 2014, Vermont saw an increase of 3,655 children enrolling in Dr. Dynasaur.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of the PPACA impacted the way your state administers CHIP?

   As a result of the PPACA, changes to CHIP in the state of Vermont include the transition to a modernized application process through Vermont's state-based insurance marketplace, Vermont Health Connect, and conversion of income eligibility to a simplified MAGI based methodology. In addition to PPACA requirements, Vermont took advantage of other provisions including moving the administration of the CHIP program under the Medicaid State Plan. Benefits through the CHIP program continue to be the same as those offered in Vermont's Medicaid program.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparable available through your state' s exchange or through the majority of employer sponsored health plans in your state.

   The services and benefits offered through the state's exchange are comparable to the CHIP benefit. Medicaid services include comparable essential health benefits. Vermont covers up to 138% FPL for adults under Medicaid and up to 312% for children in CHIP and in families with other insurance.

   The state of Vermont receives close to $8 million in federal funds annually to provide coverage for the CHIP population and to support Vermont's early expansion of Medicaid coverage for children. In the absence of federal funding for CHIP, Vermonters would face significant hardship, as the state would not be able to supplement the full loss of the enhanced federal match until the CHIP authorization ends in 2019. At that time states can maintain coverage or shift coverage to plans offered through the exchange. For a single parent with a child out of pocket costs on the exchange range from $180–$628 per month. This is a substantial increase from the $60 a month premium for CHIP.

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe that CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

   The state of Vermont strongly recommends that CHIP funding be extended through the federal Title XXI authorization period to 2019. Failure to extend CHIP funding would result in a significant financial burden to the State, could result in many children becoming uninsured and would increase the cost of coverage for many who would remain insured. Continued funding would also allow

states time to plan for a transition if needed and to assure that children will receive continued coverage.

The elimination of CHIP funding in 2015, will have a financial burden to the state. CHIP authorization requires Medicaid Expansion states including Vermont, to maintain the current level of coverage through 2019. Even with unspent funds from prior years, federal estimates indicate that CHIP will run out of money early in FY2016. The state will have to subsidize the loss of enhanced match. As state budgets are increasingly tight, this could mean the elimination of services for state funded programs outside of CHIP. Vermont relies on the enhanced federal match to provide healthcare coverage for CHIP enrolled children.

Elimination of CHIP will also have a detrimental effect on coverage for children in 2019. CHIP is an extremely successful program significantly increasing children's coverage in Vermont and across the nation. In the absence of CHIP, enrollees could obtain coverage through the state's marketplace, Vermont Health Connect, however there is potential for over 7,000 children to become uninsured. Depending on the plan they choose, families would have to pay higher premiums, deductibles and co-pays. This places an increased financial hardship on families, regardless of whether or not they are eligible for a subsidy.

Nationally, CHIP covers more than 8 million low-income children, CHIP and Medicaid combined cover more than 1 in every 3 children in the United States. Research indicates that for families below 150% FPL a premium increase to $120 is associated with a 5% increase in uninsured children.[1]

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting on 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

   The 2009 restructuring and retargeting of allotments has improved the state of Vermont's ability to spend down the state's allocation. The formula change allows Vermont to receive full compensation based on funds expended. In FY 13, Vermont had less than 1% in unspent funds.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job of enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children reduce the number of the uninsured, and improve health outcomes for children in your state?

   As state budgets are increasingly tight, there is no guarantee that states will be able to maintain coverage for children beyond 2019, without federal appropriation. Continued federal support that would increase enrollment includes augmenting the state's ability to identify and enroll children who are eligible for CHIP or Medicaid but have not enrolled through incentives and funding for outreach.

   Other policies to support health outcomes include providing incentives to states to increase evidence-based practices in primary care for children, supports for analyzing pediatric quality measures, and linking quality measures to clinical decision support. Federal policies requiring universal coverage for all children will insure that states can enroll children and reduce the number of uninsured. Vermont is moving in the direction of coverage through a publicly funded, universal health care system. Under this system, eligibility will be based on residency, which will guarantee that all children have access to coverage. If federal policy for universal coverage for all children is impracticable for all states, we feel strongly that Vermont should receive federal support for its health care reform efforts.

Please feel free to reach out should you need additional input or clarification regarding the contents of Vermont's responses.

Sincerely,

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[1] Salam Abdus, Julie Hudson, Steven C. Hill and Thomas M. Selden, *Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children,* Health Affairs, 33, no. 8 (2014):1353–1360.

Peter Shumlin
Governor

Cc: Senator Patrick Leahy
Senator Bernie Sanders
Congressman Peter Welch
Secretary Hany Chen, Vermont Agency of Human Services
Commissioner Mark Larson, Department of Vermont Health Access

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Terence R. McAuliffe
Governor

October 23, 2014

The Honorable Ron Wyden
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The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
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2183 Rayburn House Office Building
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The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
U.S. Senate
104 Hart Office Building
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The Honorable Henry Waxman
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
2204 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Wyden and Upton, and Ranking Members Hatch and Waxman:

I am writing in response to your July 29, 2014 letter to states requesting information about our Children's Health Insurance Program (CHIP) in the context of the funding reauthorization. Thank you for the opportunity to provide information about Virginia's very successful CHIP programs, called Family Access to Medical Insurance Security (FAMIS) that provide comprehensive health care coverage to approximately 200,000 children and pregnant women in Virginia's low-income working families. These families earn 200% or less of the Federal Poverty Level (FPL), or up to $39,580 a year for a family of three.

FAMIS has enjoyed bi-partisan support in Virginia and is viewed as a bridge program for families earning too much to qualify for Medicaid, but yet not enough to afford employer or Marketplace insurance. While the Marketplace provides new affordable health care options for adults, there remain some significant concerns for children's coverage especially for those 200% or less of FPL. These concerns include barriers to affordable coverage because of the "family glitch" (determining affordability based on the cost of employee-only coverage instead of family coverage); lack of comparable child-specific benefit plans; exclusion of the cost of stand-alone pediatric dental plans in the calculation of subsidies; and annual out-of-pocket cost sharing that far exceeds the CHIP affordability limit (5% of income).

Attached are answers to your questions which outline the importance of our programs and the coverage they provide to the children and pregnant women in the Commonwealth. Without Congressional action, Virginia will not have enough federal carryover funding to continue the program in federal fiscal year 2016. I urge Congress to fund the CHIP program for an additional four years through 2019 at the enhanced 23 percentage point match rate, because Virginia, like many other states, has already budgeted for this enhanced funding established in the Affordable Care Act. The four years of CHIP funding will provide the needed time to evaluate coverage for children through the Marketplace while continuing to provide quality health care through a proven and effective program.

Please contact Linda Nablo with the Department of Medical Assistance Services (DMAS) for any additional questions about our programs.

Sincerely,

Terence R. McAuliffe

Attachment

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

Virginia has a combination CHIP program made up of two components that covered over 196,000 otherwise uninsured children during FFY 2013:

a. A separate CHIP (S–CHIP) program called Family Access to Medical Insurance Security (FAMIS) covered over 104,000 children, ages 0–18, living in families with incomes between 134% FPL and 200% FPL in FFY 13. *These FPL limits were converted to 144–200% during the Modified Adjusted Gross Income (MAGI) conversion at the beginning of FFY 2014;* and

b. An expansion of Medicaid paid for by CHIP funding (M–CHIP) covered approximately 92,000 additional children, ages 6–18, living in families with incomes between 100% and 133% FPL in FFY 13. *These FPL limits were converted to 110–143% during the Modified Adjusted Gross Income (MAGI) conversion at the beginning of FFY 2014.*

Approximately forty-one percent (41%) of Virginia's CHIP enrollees are Caucasian; twenty-six percent (26%) are African American; nineteen percent (19%) are Hispanic; four percent (4%) are Asian; and the remaining ten percent (10%) identify themselves as a mixed race or another racial group. Forty-nine (49%) of the enrollees are female while fifty-one percent (51%) are male. Ninety percent (90%) of families report English as their primary language while nine percent (9%) report Spanish as their primary language.

About ninety-five percent (95%) of Virginia's CHIP enrollees are served through a managed care organization (MCO) delivery system for the majority of their health care needs. Virginia's contracted MCOs are required to obtain and maintain accreditation with the National Committee for Quality Assurance (NCQA). Quality outcomes are monitored by the state in part through Healthcare Effectiveness Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. As compared to the benchmark of HEDIS® 2013 National Medicaid Managed Care 50th Percentile, the Virginia MCO average for services provided in 2012 met or exceeded the benchmark for the following measures:

- Six or more well-child visits in the first 15 months of life
- Annual well-child visits in the third, fourth, fifth, and sixth years of life
- Use of appropriate asthma medication (ages 5–11 and 12–18)

Key findings from Virginia's 2013 CAHPS survey of FAMIS enrollees show that more than eight in ten parents/guardians gave positive satisfaction ratings of their child's Personal Doctor (89%), Specialist (85%), Health Care overall (85%) and Health Plan overall (84%); and for parents/guardians of children with chronic conditions more than eight in ten gave positive satisfaction ratings of their child's Personal Doctor (91%), Health Care overall (87%), Specialist (87%) and Health Plan overall (84%). In addition, sixty-two percent (62%) of three to eighteen year olds enrolled in FAMIS received a dental service during the state fiscal year (SFY) 2013.

The Centers for Medicare and Medicaid Services (CMS) PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program. The National average PERM rate is 6.1%. For FY 2012, Virginia's most recent Managed Care program PERM rate was less than 1%.

Additionally, Virginia has an 1115 waiver through CHIP that provided prenatal care, delivery, and postpartum coverage to over 4,600 women over age 18 living in families with incomes between 134% FPL and 200% FPL in FFY 2013. Based on External Quality Review studies, low birth weight rates for Virginia's program have continued to improve during the three year period 2011–2013 and outperformed the Centers for Disease Control national benchmark for all three years. Virginia MCO

HEDIS score for the first trimester prenatal care was 86%, exceeding the National HEDIS Medicaid average rate.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act (PPACA)? How has the implementation of PPACA impacted the way your state administers CHIP?

To align with the Federal Marketplace's first open enrollment, Virginia was an early adopter of the new MAGI eligibility methodology which we began to use in October 2013 at the same time we launched our new Eligibility and Enrollment system that determines eligibility for both Medicaid and CHIP. In July of 2014, following the issuance of new regulations by CMS, we also removed the four month waiting period after dropping health insurance for S–CHIP applicants. In addition, we are currently in the process of submitting a state plan amendment to allow dependents of state employees to enroll in our S–CHIP program starting January 1, 2015—an option made available to states through the ACA.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Virginia's separate CHIP program, FAMIS, provides comprehensive health care benefits originally modeled after the state employee health insurance benefits, but tailored to meet the specific health care needs of children. These benefits are not limited to well and sick care visits, prescriptions, hospitalization, and vision care, but include comprehensive dental coverage including medically-necessary orthodontia, Early Intervention services, school health services, and substance abuse treatment services as well as non-traditional behavioral and psychiatric services.

FAMIS has no monthly or annual premiums and very affordable co-pays. For most services under FAMIS, the co-pay is only $2 or $5 and there are no co-pays above $25. In addition to not charging co-pays for well child check-ups, there are no co-pays for dental care. Cost sharing cannot exceed $180 per family per calendar year if a family's gross income is less than 150 percent of the federal poverty level and $350 per family per calendar year if gross income is more than 150% of the federal poverty level. Based on the July 2014 *Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified Health Plans* prepared by the Wakely Consulting Group for the Robert Wood Johnson Foundation, FAMIS has much lower average annual cost sharing and out of pocket maximum than a silver qualified health plan (QHP):

Enrollees with family incomes of 160% FPL	FAMIS	QHP in Federal Exchange
Average Annual Cost Sharing	$89	$411–$480
Out of Pocket Maximum	$350	$1,500–$2,250

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

Yes, we strongly recommend the funding for CHIP be aligned with the current authorization of the program through 2019 and should include the ACA authorized twenty-three percentage point increase in the Federal Financial Participation (FFP) match rate. While the Marketplace provides new affordable health care options for adults, there remain some significant concerns for children's coverage, especially for those under 200% FPL. These include barriers to affordable coverage because of the "family glitch;" lack of comparable child specific benefit plans; exclusion of the cost of stand-alone pediatric dental plans in the calculation of subsidies; and annual out-of-pocket cost sharing that far exceeds the 5% of income affordability limit of CHIP.

We do not have estimates for how many separate CHIP enrollees covered during the year would become uninsured if CHIP is not funded, but approximately 104,000 Virginia children would be in jeopardy of becoming uninsured. According to our projections submitted in our August 2014 CMS 37/21B report, we do not project a CHIP

allotment carryover from FFY 2015. Therefore, Virginia would have no federal funds available to continue coverage for these children into FFY 2016.

We project that we will need $356,175,917 in total funds to continue our CHIP programs in FFY 2016. For our S–CHIP program alone, Virginia expects to need $219,644,400 in total funds to continue the program. Eighty-eight percent (88%) of that or $193,287,072 is currently budgeted to come from the federal government due to the twenty-three point increase in the state's Federal Financial Participation (FFP) match rate starting with FFY 2016. While we believe that FAMIS is a successful and needed program, if CHIP is not funded, Virginia will not be able to absorb the federal share and continue the S–CHIP program with state funds only.

In addition to concerns about children in our separate CHIP program becoming uninsured if CHIP funding is not extended, Virginia also has serious concerns about funding the M–CHIP program. Without the expected CHIP funding at eighty-eight percent (88%) FFP match rate, our understanding is that we would be required to continue to cover these children under the Maintenance of Effort (MOE), but that our match rate for covering these children would fall to the regular Medicaid FFP match rate of fifty percent (50%), requiring an additional $51,881,977 in state funds for FFY 2016.

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

The allotment process was greatly improved under the 2009 CHIPRA legislation and appears to be working appropriately.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

- Guarantee twelve months of continuous coverage for children.
- Eliminate requirements to prevent substitution of coverage from the CHIP program to reduce coverage barriers and streamline administration of the program. CHIP is the only publically-funded health care program with this requirement.
- Allow coverage for dependents of public employees without additional qualifying steps.
- Improve alignment of coverage with the Marketplace so that there is no gap in coverage when a child/family moves from CHIP or Medicaid coverage to the Marketplace.
- Enhance the electronic verification systems available to states through the HUB to reduce the need to request paper verifications.
- Allow coverage of medically-necessary Institution for Mental Diseases (IMO) placements for CHIP eligible children as is available to children covered by Medicaid.
- Allow states to claim enhanced FFP for production of materials (brochures, posters, member handbooks, TV and radio ads, etc., as well as media buys) in languages other than English, not just the translation itself.

STATE OF WASHINGTON

HEALTH CARE AUTHORITY

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October 6, 2014

The Honorable Fred Upton
Chairman
U.S. House of Representatives
Committee on Energy and Commerce
2183 Rayburn House Office Building
Washington, DC 20515

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Henry A. Waxman
Ranking Member
U.S. House of Representatives
Committee on Energy and Commerce
2204 Rayburn House Office Building
Washington, DC 20515

The Honorable Orrin G. Hatch
Ranking Member
U.S. Senate
Committee on Finance
104 Hart Office Building
Washington, DC 20510

Dear Senators Wyden and Hatch and Representatives Upton and Waxman:

SUBJECT: Extending Funding of the Children's Health Insurance Program

Thank you for the opportunity to provide input as federal policymakers considers extending funding of the Children's Health Insurance program (CHIP). Washington State is supportive of extending funding of the CHIP program through 2019. Below we have provided responses to the questions posed. We hope our responses resonate with Congress and other states in continuing this popular and effective program for providing health care coverage for children.

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

   State's response: *Washington State provides health care coverage for nearly fifty thousand low-income children each year under its stand-alone CHIP program. Average monthly enrollment exceeds 38,000. Coverage is provided to unborn children whose mothers do not qualify for Medicaid because of citizenship status, but family income is at or below 193 percent federal poverty level (FPL), and to children birth through age eighteen whose family income is at or below 312 percent FPL. Thirty-two percent of the children birth to age 19 served by Washington's CHIP are members of an ethnic minority. Eighty-five percent of the children enrolled in CHIP receive their coverage via a Managed Care Plan.*

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of the PPACA impacted the way your state administers CHIP?

   State's response: *Over the last year, Washington State has implemented a highly successful state-based exchange—www.wahealthplanfinder.org. Through this exchange portal, individuals and families can apply for the full range of subsidized insurance options including Medicaid (Apple Health) and CHIP (Apple Health with premiums). Applicants who use the web portal receive an eligibility decision in "real-time" based on Modified Adjustable Growth Income. This has dramatically improved the timeliness of service delivery and reduced delays in accessing needed medical care.*

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

   State's response: *The benefit package under CHIP is the same as that offered children under Medicaid, and has an actuarial value of 100 percent. This value is over 25 percent higher than the actuarial value of a subsidized silver level plan in the exchange. There is no cost-sharing for this coverage other than a nominal $20–$30 per monthly premium based on income, applied to a maximum of two children each household. In addition, CHIP coverage offers a richer set of services beyond the ten essential health care benefits in the exchange plans, including Early Periodic Screening, Diagnosis and Treatment, Health Homes, Personal Care Services, Tobacco Cessation Counseling, Targeted Case Management, Nursing Facility-Long-Term Care, and Intermediate Care, Individuals with Intellectual Disabilities Facilities for the Developmentally Disabled.*

4. Do you recommend that funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

State's response: *We strongly support Congress acting to extend funding of CHIP for a minimum of two years as recommended in the June 2014 MACPAC report. We believe an additional two-year extension to 2019 will allow Congress and the states the necessary time for the exchanges and health care networks to mature without negative impacts to the health care of our nation's children. We believe CHIP has been instrumental in providing effective health care coverage for uninsured children for the last 15 years. We would urge Congress to act no later than March 2015 to extend funding for CHIP if the State is to avoid development costs associated with eliminating the program in fiscal year 2015. If funding for CHIP is not authorized in FY 2016, 12,000 unborn children annually will not have access to prenatal coverage.*

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

   State's response: *In recent years, Washington State's CHIP expenditures have met or exceeded the available allotment. Given the 20 percent increase in our CHIP enrollment over the last year, we would ask that Congress consider a formula for establishing Washington's annual allotment that recognizes our success in operating a state-based exchange. Washington occupies a unique niche as a §2105(g) qualifying state. If the allotment formula for our state is not substantially modified, we estimate a loss of federal revenue in excess of $50 million dollars. We would also recommend Congress address the issue of unspent allotments by extending the enrollment performance bonus authorized under the Children's Health Insurance Program Reauthorization Act (CHIPRA).*

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of the uninsured, and improve health outcomes for children in your state?

   State's response: *We support Congress establishing a unified set of Pediatric Quality measures as described in CHIPRA. We believe Congress could encourage states to pursue improved health outcomes by supporting adoption of such quality measures with enhanced federal funding (similar to performance bonuses for enrollment). Further, we believe grant funds should continue to be designated for pediatric institutions to continue the study, development, and measurement of improved health outcomes for children and adolescents.*

Thank you for the opportunity to review your request and answer your questions. Sincerely,

Sincerely,

Dorothy F. Teeter, MHA
Director

STATE OF WEST VIRGINIA
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EARL RAY TOMBLIN
GOVERNOR

October 31, 2014

The Honorable Fred Upton
Chairman
U.S. House of Representatives
Committee on Energy and Commerce

The Honorable Henry A. Waxman
Ranking Member
U.S. House of Representatives
Committee on Energy and Commerce

2183 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Ron Wyden
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
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2204 Rayburn House Office Building
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The Honorable Orrin G. Hatch
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Upton, Chairman Wyden, Ranking Member Waxman, Ranking Member Hatch, House Energy and Commerce and Senate Finance Committees:

Thank you for the opportunity to respond to your recent inquiries regarding policy considerations affecting the federal Children's Health Insurance Program (CHIP) and West Virginia's Children's Health Insurance Program (WVCHIP). Since launching WVCHIP in July 1998, we have provided coverage and access to health care services for more than 185,000 West Virginia children who were previously ineligible to receive insurance coverage through Medicaid or other insurance providers. For years, West Virginia has been a leader in reducing the number of uninsured children through WVCHIP's continued outreach efforts to protect and promote the health of West Virginia children by gradually expanding eligibility and health services to families in need.

As we continue to implement health care reform, our state's vision for CHIP services assumes enrollees would transition to receive services either through Medicaid expansion coverage or subsidized commercial plans that provide more affordable and robust coverage. As we prepare for the last year of CHIP funding, it is unlikely our vision will become a reality for significant number of West Virginia enrollees.

1) **Individuals Served:** In Federal Fiscal Year 2013 WVCHIP served an unduplicated 37,413 children. In FFY 2014, the unduplicated enrollment decreased to 33,767, a 9.7% decrease in part due to the Medicaid child eligibility expansion to 133% federal poverty level (FPL) income level. On December 31, 2013, WVCHIP monthly enrollment was 25,011, prior to the transition of all WVCHIP enrollees to Medicaid by December 31, 2014, at which date the WVCHIP enrollment is estimated to total 19,557.

   Since the creation of the WVCHIP program, the demographics of West Virginia children receiving available services have evolved. In 2000, WVCHIP expanded its eligibility income level in several phases from 200% FPL and again in 2011 to 300% FPL. On July 1, 2014, children of public employees also became eligible to receive WVCHIP coverage. A past comparison of non-disabled WVCHIP children and non-disabled Medicaid children showed the WVCHIP population were identified by higher risk adjustment factors (were sicker) than Medicaid children. Simply put, CHIP and WVCHIP are serving a population of our state's children that Medicaid is not.

2) **CHIP Changes under PPACA:** The most significant changes to CHIP operations resulting from PPACA include those policy changes requiring the MAGI income counting rules and implementing operational changes to the eligibility system and electronic claims systems. While these updates are necessary enhancements, they have required significant resources and commitment, by not only WVCHIP, but from all those systems which provide similar administrative functions for the State's Medicaid program.

3) **Premiums and Copayments:** WVCHIP currently applies both modest premiums and copayments to different income tiers as follows:

Premiums and Selected Cost Sharing in West Virginia's CHIP Program, 2014

Family Income Level	Premiums	Office Visits	Inpatient Services	Prescription Drugs
≤150% FPL	None	$5 *	None	$0–$5
>150–211% FPL	None	$15–$25 *	$25	$0–$10
>211% FPL	$35/$71 max **	$20–$25 *	$25	$0–$15

*Waived when member has a designated medical home.
**There is a single child family rate vs. multi-child family rate.

NOTE: *Premiums and cost sharing are set within federal parameters, i.e., in total, any family contribution to the cost of coverage cannot exceed five percent of family income.*

WVCHIP currently collects more than $900,000 in premium payments each year from families with incomes over 200% up to 300% FPL level. In 2013, approximately one-third of these families fell behind on premium payments and/or cancelled their enrollment.

Lack of Affordable Options and Increase in Uninsured Children: If federal funding for CHIP is eliminated in 2015, current enrollees will be given the option to enroll in Qualified Health Plans (QHP) in West Virginia's Marketplace. We expect more than half of WVCHIP enrollees would drop enrollment during the benefit year, as the affordability of premium levels for family coverage of four would be challenging, even with the tax subsidy. The average monthly premium cost for a silver plan in West Virginia's Marketplace covering a family of four at the 139% FPL level would be $354 with a $200 deductible. The same WVCHIP family now pays no monthly premium. The silver plan average monthly premium cost for a family of four at the 300% FPL would be $824 with a $9,500 deductible. The most affordable bronze plan for a family of four at the 139% FPL has an average monthly premium of $253 with a $10,000 deductible. This same plan for a family of four at the 300% FPL level would be an average monthly premium of $723 with a $10,000 deductible. Even if these families could afford the cost of premium, the deductibles are a significant access barrier to services offered to WVCHIP children. This is especially the case for dental services where families would bear a $350 deductible per child up to a $700 deductible per family for dental care. WVCHIP has some $25 copayments for a handful of lesser used services, but there are no deductibles for dental. This information is summarized in the chart below.

West Virginia Qualified Health Plans' Premiums and Deductibles

Family Size and Income	Silver Plan *Premiums*	Silver Plan *Family Deductible*	Bronze Plan *Premiums*	Bronze Plan *Family Deductible*
4 (139% FPL)	$354/month	$200	$253/month	$10,000
4 (300% FPL)	$824/month	$9,500	$723/month	$10,000

In addition to the substantial increase in cost sharing for families, children would not receive the same health services as QHPs in the Marketplace were not created with the unique needs of children in mind. An important value of a pediatric-centered benefit is to assure coverage and access of preventive services, which WVCHIP does with no copayments or deductibles. WVCHIP children between the ages of three years to six years accessed well child visits at a 77.4% rate last year and 76.4% the year before. We would expect to see this rate and other preventive services decrease for CHIP children if they are subject to copayments and deductibles.

4) **Recommended Extension for Four Years:** We recommend consideration of a four-year CHIP extension. This extension would allow for further market development and stabilization with potentially more affordable choices for more West Virginians. In 2014, the total percentage or children enrolled in QHP plans was quite low (less than 1%). It would take at least two or three more budget cycles to determine the participation rates for CHIP income populations in QHPs. To determine whether enrollees are better served in alternative Medicaid bridge plans or under a basic health plan option would require an extension.

QHP Non-Affordability for West Virginia CHIP Households: In the spring prior to the 2014 Marketplace enrollment, a survey of WVCHIP households was completed. The results found more than half of the surveyed households indicated they could pay only $50 per month in premiums for family coverage, considerably less than QHP premium rates. Based on this survey and without an extension of CHIP funds, we believe children currently receiving WVCHIP coverage and benefits could potentially become uninsured, resulting in increased uncompensated care costs for providers and unmet healthcare needs for children. While our ultimate goal remains to achieve a better

Marketplace/public coverage fit for these families in whatever means possible, not extending CHIP funds would be a significant step backward for the health of West Virginia children.

5) **The Allotment Formula:** WVCHIP has been managed through strong fiscal management efforts, and federal dollars have always been sufficient to meet the needs of those enrolled. Since the CHIP Reauthorization Act (CHIPRA) of 2009, the basic allotment funding formula has worked well to support our state's program even during phased in expansion periods. This has allowed West Virginia to continue to expand the program within the parameters of its budget and reduce the number of uninsured children. CHIPRA special contingency funds and bonus set aside for enrollment incentives were less effective clue to the current successes in terms of increased enrollment for children in our state as well as the efficient implementation of stream lining enrollment changes. CHIP allotments must now be split between WVCHIP and Medicaid, which causes us great pause as CHIP funds may be used at a more rapid rate, potentially leading to federal funding shortfalls. If federal funding to support CHIP is not extended, WVCHIP will be terminated due to state statute requiring the elimination of the program if federal funds are no longer sufficient. Without the extension of CHIP federal funds, thousands of West Virginia children and families will be impacted.[1]

Federal Funds Shortfall Projection: WVCHIP's actuary currently projects the program could start to experience a funding shortfall as early as first quarter Federal Fiscal Year 2016 (December 2015) without additional federal appropriations after 2015.

The CHIP Allotment Post Federal Fiscal Year 2015
Currently no Title XXI funds are allotted for the program past federal fiscal year 2015. The "separate" CHIP has $41,806,543 in projected costs for 2016 based on current projected enrollment and trends. The "expansion" CHIP has projected 2016 costs of $22,900,000. If the "enhanced" federal matching percentage (FMAP) is increased by 23%, as stated in the ACA, and additional federal funding is allotted, the federal cost for CHIP in West Virginia would be $64,706,543. There would be no state share, as West Virginia's federal matching percentage would be 100% (2016 enhanced FMAP = 79.99% + 23% = 100% FMAP cap). If the 23% increase to the enhanced FMAP is disregarded, and sufficient funding is allotted at the federal level, the federal cost for CHIP in West Virginia would be $51,758,764, while the state cost would be $12,947,779. If no funding is allotted at the federal level post 2015, West Virginia would have state costs of $41,806,543 to continue the "separate" CHIP. The "expansion" CHIP would continue to be funded at the regular FMAP using Title XIX funds. The projected federal cost for the "expansion" CHIP in 2016 is $16,355,180 and state funding of $6,544,820 at the regular FMAP. This represents an additional state cost of $1,962,530 compared to the enhanced FMAP currently available or $6,544,820 compared to enhanced FMAP with the 23% increase. The unknown is the additional costs to families who move from CHIP coverage to the marketplace or from CHIP coverage to being uninsured because of rules regarding marketplace eligibility—most notably the "family glitch," or to affordability issues mentioned above. The state will also bear the uncompensated costs for those children who cannot enter the Marketplace.

Federal Budget Action Timeline: It is important to stress action must fall early within the 2015 current year's cycle, as the state would amend its State Plan by the second quarter in the 2015 calendar year to allow time to close enrollment six months in advance of the December 2015 date. If Congress were to delay a decision on a CHIP funding extension until late 2015 for the 2016 budget cycle, it could come too late to continue West Virginia's program.

6) **Furthering Children's Enrollment, Reductions in Uninsured Children:** West Virginia continues to streamline its enrollment processes, particularly re-enrollment so as to not eliminate coverage for children due to noncompliance for timely response. We know many children dropped from the rolls at renewal remain eligible, and children are re-enrolled as soon as they are sick or have

[1] ***§5–16B–8. Termination and reauthorization.*** *(a) The program established in this article abrogates and shall be of no further force and effect, without further action by the Legislature, upon the occurrence of any of the following: (2) The effective date of any reduction in annual federal funding levels below the amounts allocated and/or projected in Title XXI of the Social Security Act of 1997.*

coverage need. Policy changes such as including Express Lane Eligibility as a permanent option or incentivizing coverage renewal at the time of SNAP enrollment would minimize this administrative inefficiency and promote better continuity of care for children. These changes also help lower caseloads for a workforce that has been severely stretched since recessionary pressures caused spikes in enrollment of safety net programs. In considering further incentives, most states are likely to continue to streamline enrollment where possible. The most important incentive would be one which would address continued lowering of the children's uninsured rate.

Improving Health Outcomes: West Virginia has been a participant in a CHIPRA Pediatric Quality Demonstration grant concerning medical home and quality measurement—work that has been challenging and complex and is drawing to a conclusion this year. It is critical that states have such funds to work on quality changes and identify performance drivers in the health care delivery system with the child population as its main focus. While much of the focus for federal funding has been tailored toward the chronically ill adult population, in many cases it leaves the needs of children out of the equation or in a secondary place of consideration. The importance of continued use of CHIP federal funding allotment to incentivize states to continue children's quality work cannot and must not be understated.

In conclusion, West Virginia continues to face changing budgetary times. Without an extension of CHIP federal funding to help sustain child health care coverage while Marketplace options for children are evaluated and improved upon, we will not be able to provide the health care coverage our children need.

Sincerely,

Earl Ray Tomblin
Governor

State of Wisconsin
Department of Health Services

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Protecting and promoting the health and safety of the people of Wisconsin

Scott Walker, Governor
Kitty Rhoades, Secretary

September 2, 2014

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Senator Ron Wyden
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104 Hart Senate Office Building
Washington, DC 20510

Dear Representative Upton, Representative Waxman, Senator Wyden, and Senator Hatch:

Governor Walker asked me to respond to your recent letter asking for input on the Children's Health Insurance Program (CHIP).

In Wisconsin, CHIP funding is integrated with the state's Medicaid coverage for children and low income families, called BadgerCare Plus. Using the combination

of federal Medicaid and CHIP funds and state match, Wisconsin provides health coverage to children up to 300% of federal poverty level (FPL).

The following are answers to your specific questions:

1. As of June 2014, Wisconsin had 38,652 children in CHIP. The populations served by the CHIP program in Wisconsin currently include:

- Children aged 1 through 5 years with incomes between 185% and 300% of the FPL.
- Children aged 6 through 18 years with incomes between 133% and 300% of the FPL.
- Unborn children of women not eligible for Medicaid with incomes up to 300% of the FPL.

2. As required under the Patient Protection and Affordable Care Act (PPACA), the state has implemented modified adjusted gross income (MAGI) rules for CHIP funded children. Wisconsin has maintained income eligibility levels for all Medicaid and CHIP funded children. Effective April 1, 2014, the state began providing Medicaid Standard Plan benefits coverage to all adults and children in the Medicaid and BadgerCare Plus program, including CHIP funded children. Previously, children above 200% FPL were enrolled in a benchmark health plan, whose benefits were consistent with commercial insurance. In another change resulting from PPACA, the state has begun processing CHIP applications received from the federal health insurance exchange.

3. The Standard Plan offered to all Medicaid and CHIP funded individuals includes more generous dental, prescription drugs, mental health, transportation, and long term care benefits, as well as lower cost sharing requirements, than plans offered through the health insurance exchange or in other commercial coverage. A list of Standard Plan benefits is available at: *http://badgercareplus.org/standard.htm.*

4. Wisconsin recommends that CHIP funding be extended and that Congress act to do so before the expiration of the funding authorization at the end of federal fiscal year 2015. In FFY14, Wisconsin's CHIP allotment was $109,462,826, representing an important component of funding the state devotes to health coverage for low income children. It is crucial for Congress to provide states with predictable funding levels in the coming years. Wisconsin recommends that CHIP be extended at least for the duration of the PPACA requirement that states maintain current eligibility levels for children. This requirement is in place through September 2019. As noted above, CHIP funding supports over 38,000 children in Wisconsin. Also Wisconsin receives the CHIP enhanced federal Medicaid matching rate for some children 6 to 18 years old who are between 100% and 133% of the FPL and children under age 6 with incomes over 133% of the FPL and below Medicaid income limits.

5. In general, the current allocation formula has been sufficient for Wisconsin. It is important for Wisconsin at minimum to keep its current allocation. Congress may wish to consider indexing states' allocations to reflect population growth or health care inflation.

6. The most useful thing the federal government can do is provide states with as much flexibility as possible to design programs to meet each state's unique needs for health coverage.

Thank you again for your letter. Please feel free to contact me or my staff if you need any additional information.

Sincerely,

Kitty Rhoades
Secretary

Response from the State of Wyoming

1. How many individuals are served by your state's CHIP program? What are the characteristics of CHIP enrollees in your state (e.g. income, health status, demographics)?

- 5,220 average monthly enrollment, SFY 2014.
  - Serve youth 0–19 years of age, with thirty-six (36%) of CHIP recipients being between seven (7) and eleven (11) years of age; only four percent (4%) between zero and two (2) years of age.
  - Even distribution of male and female youngsters.

  - Sixty-five percent (65%) of CHIP population live in seven (7) of the twenty-three (23) counties.
  - Sixty-four percent (64%) of CHIP families have incomes between 151%–200% FPL (prior to Jan. 2014); seventy-seven percent (77%) of CHIP families have incomes between 151%–200% FPL (post Jan. 2014).

- Seventy-one percent (71%) of all CHIP recipients utilized a medical benefit, including pharmacy, during a 12-month period of time.
  - Professional services such as diagnostic lab, x-ray, optical exams and urgent care services account for forty-four percent (44%) of delivered services.
  - Institutional services (inpatient) for treatment of ailments such as psychoses and depressive neuroses account for twenty-four percent (24%) of delivered services.
    * The catastrophic claims classification ($50,000+) is comprised of twenty-two CHIP recipients, with eleven (11) of the twenty-two catastrophic claims being for inpatient treatment of psychiatric disorders.
  - Institutional services (outpatient) for treatment of ailments such as abdominal pain, bone fracture, ear ache account for twenty-one percent (21%) of delivered services.
  - Prescription Drugs account for eleven percent (11%) of services.
    * Antiasthmatic, AD HD treatment, a variety of antibiotics and dermatological pharmaceuticals are the most prevalent.

- Fifty-three percent (53%) of all CHIP recipients utilize a dental benefit during a 12-month period of time.
  - Services such as sealants, fluoride, varnish, x-rays account for 54% of services delivered.
  - Services such as fillings and crowns account for 27% of services delivered.
  - Five hundred forty-four (544) youngsters received oral surgery services.
  - Orthodontic services are growing at a higher rate than other services.

Data indicates that overall the CHIP population is quite healthy, utilizing services to address health issues as they present, and are reactionary in nature. Preventive services, such as well-child and well-adolescent checks are not utilized as frequently even though there is no co-pay for preventive services. Limited data suggests an hourly wage parent/caregiver may consider it too costly to forego work in order to schedule a well-child exam.

2. What changes has your state made to its CHIP program as a result of the Patient Protection and Affordable Care Act? How has the implementation of PPACA impacted the way your state administers CHIP?

- CHIP enrollment processes are now conducted in a centralized Customer Service Center.
- CHIP eligibility is now determined by a new integrated eligibility system, the Wyoming Eligibility System (WES) that ascertains CHIP and Medicaid eligibility with a single, streamlined application.
- Implementation of the new Modified Adjusted Gross Income (MAGI) based income standard deemed approximately 1,251 CHIP enrollees Medicaid eligible. The identified youth were transitioned to Medicaid beginning January 1, 2014.
- Verification is now required for reported income. Previous to the ACA income amounts were provided via self-declaration.
- Previous to the ACA, a social security number was not necessary for CHIP application. A social security number is now required for each individual on the application applying for CHIP enrollment.

The administration of the eligibility and enrollment elements of the program have shifted from in-house eligibility staff to a customer service center with the CHIP Eligibility Manager providing administrative oversight of the work conducted by the customer service center staff.

The administration of the Federal CHIP requirements including State Plan and Amendments, Federal Reporting, strategic planning, coverage and benefit requirements, outreach and education activity have remained as they were prior to the ACA for the CHIP Program Manager.

3. To the extent the following information is readily available and you believe it is relevant, please describe the services and or benefits and or cost sharing currently provided in your state under CHIP that are not comparably available through your state's exchange or through the majority of employer sponsored health plans in your state.

Kid Care CHIP	*Marketplace*
Premium: None	Premium: $771/mo–$1,159/mo
Deductible: None	Deductible: $2,000/yr–$3,000/yr
Out of Pocket max: 5% annual gross income	Out of Pocket max: $3,000/yr–$12,700/yr
Dental benefits: included in benefit package	Additional deductible or separate policy

4. Do you recommend that CHIP funding be extended? If so, for how long, and for budgeting and planning purposes, under what timeframe should Congress act upon an extension? If you do not believe CHIP funding should be extended, what coverage (if any) do you believe CHIP enrollees in your state would be able to obtain? How many children covered by CHIP do you estimate would become uninsured in the absence of CHIP?

The recommendation would be for the extension of CHIP beyond September 30, 2015. The principal rationale for the recommendation is the vast majority of youth currently enrolled in CHIP would not have any viable options in the Marketplace nor would they be eligible for Medicaid. In addition, it is unlikely the CHIP family would be eligible for a tax credit as the formula to determine tax credit eligibility is based on the employee's share of the premium exceeds 9.5% of the employee's adjusted gross income. The option of the State absorbing the 65% match currently provided at the Federal level is not probable. The result would be a significant number of children returning to the rolls of the uninsured, defeating one of the purposes of the Affordable Care Act (ACA).

5. In spite of the restructuring and retargeting of allotments that occurred in 2009, some CHIP funding remains unspent. Do you believe the annual allotments your state has received starting in 2009 have been sufficient and the formula is working appropriately? Do you believe there is a need for Congress to further address the issue of unspent allotments?

The allotments we have received have been sufficient, and since 2009 unspent allotment monies have been returned for redistribution. Perhaps there is an opportunity for Congress to readdress the use of unspent allotment dollars as a means to transition CHIP programs in a seamless fashion, and avoid children returning to the rolls of the uninsured. Retention of unused allotment monies would allow states to begin to develop options, such as subsidizing an affordable child only policy in the Marketplace.

6. Over the past number of years, States have worked to reduce the number of uninsured children, and Medicaid and CHIP have been a critical component of that effort. Do you believe there are federal policies that could help states do an even better job in enrolling eligible children? What other policy changes, if any, would help improve enrollment of eligible children, reduce the number of uninsured, and improve health outcomes for children in your state?

The CHIP program is a Federal and State partnership with each partner participating to the extent politically and economically feasible. To date numerous program options have been offered at the Federal level to State CHIP programs. Our State has embraced several of the program options, but not all options. There are currently no impediments to expanding the outreach and enrollment efforts from a federal level.

PREPARED STATEMENT OF HON. SYLVIA MATHEWS BURWELL, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Hatch, Ranking Member Wyden, and Members of the Committee, thank you for the opportunity to discuss the President's FY 2016 Budget for the Department of Health and Human Services (HHS).

The Department has made historic strides towards ensuring that all Americans can lead healthy and productive lives. Today, thanks to the Affordable Care Act (ACA), middle class families have more security, and many of those who already had insurance now have better coverage. In the past year alone, about 10 million uninsured Americans finally gained health insurance. In the private market, millions more now have access to expanded coverage for preventive health care services, such as a mammogram or flu shot, without cost sharing. At the same time, as a nation we are spending our health care dollars more wisely and starting to receive higher quality care.

In part due to the ACA, households, businesses, and the Federal Government are now seeing substantial savings. Today, health care cost growth is at exceptionally low levels, and premiums for employer sponsored health insurance are about $1,800 lower per family on average than they would have been had trends over the decade that preceded the ACA continued. Across the board, the Department has continued its commitment to the responsible stewardship of taxpayer dollars through investments in critical management priorities. We have strengthened our ability to combat fraud and abuse and advance program integrity, further driving savings for the taxpayer while enhancing the efficiency and effectiveness of our programs.

The Department has done important work addressing historic challenges, including the coordinated whole-of-government responses to Ebola both here at home and abroad and to last year's increase in unaccompanied children crossing the Southwest border into Texas.

The President's FY 2016 Budget for HHS builds on this progress through critical investments in health care, science and innovation, and human services. The Budget proposes $83.8 billion in discretionary budget authority, an increase of $4.8 billion from FY 2015 appropriations. This additional funding will allow the Department to make the investments that are necessary to serve the millions of American people who count on our services every day, while laying the foundation for healthier communities and a stronger economy for the middle class in the years to come. The Budget also further strengthens the infrastructure needed to prevent, prepare for, and respond to future challenges effectively and expeditiously.

The Department's Budget request recognizes our continued commitment to balancing priorities within a constrained budget environment through legislative proposals that, taken together, would save the American people a net estimated $228.2 billion in HHS programs over 10 years. The Budget builds on savings and reforms in the ACA with additional measures to strengthen Medicare and Medicaid, and to continue the historic slow-down in health care cost growth. Medicare proposals in our Budget, for example, more closely align payments with the costs of providing care, encourage health care providers to deliver better care and better outcomes for their patients, improve access to care, and create incentives for beneficiaries to seek high value services.

PROVIDING ALL AMERICANS WITH ACCESS TO QUALITY, AFFORDABLE HEALTH CARE

The President's FY 2016 Budget request builds on progress made to date by focusing on access, affordability, and quality—goals that we share with Congress and hope to work on together, in partnership, moving forward. The Budget also continues to make investments in Federal public health and safety net programs to help individuals without coverage get the medical services they need, while strengthening local economies.

Expanding Options for Consumers through the Health Insurance Marketplaces. The ACA is making quality, affordable health coverage available to millions of Americans who would otherwise be uninsured. As of mid-January more than 9.5 million consumers selected a plan or were automatically re-enrolled through the Health Insurance Marketplaces for coverage in 2015. At the same time, consumers are seeing more choice and competition. There are over 25 percent more issuers participating in the Marketplace in 2015 compared to 2014. Not only that, in 2015, nearly 8 in 10 Federal Marketplace customers can get coverage for $100 or less per month after applicable tax credits.

Partnering with States to Expand Medicaid for Low-Income Adults. The ACA provides full Federal funding to cover newly eligible adults in states that expand Medicaid up to 133 percent of the Federal poverty level through 2016, and covers no less than 90 percent of costs thereafter. This increased Federal support has enabled 28 states and the District of Columbia to expand Medicaid coverage to more low-income adults. Just recently we saw another state, Indiana, join us to bring much needed access to health care coverage to a state-estimated 350,000 uninsured low-income residents. Across the country, as of November 2014, over 10.1 million additional individuals are now enrolled in Medicaid and CHIP compared to the fall of 2013. As Secretary, I am personally committed to working with Governors across all 50 states to expand Medicaid in ways that work for their states, while protecting the integrity of the program and those it serves.

Extending the Children's Health Insurance Program. The Budget includes an additional four years of funding for CHIP through FY 2019 to provide comprehensive and affordable coverage for children and families across the United States. This ex-

tension will help bring stability to state budgets and continuity of coverage for children. We believe there is bipartisan support for CHIP and look forward to working with Congress to extend this program for the millions of children who depend upon it.

Improving Access to Health Care for American Indians and Alaska Natives (AI/AN). Reflecting the President's commitment to improving health outcomes across tribal nations, the Budget includes $6.4 billion for the Indian Health Service to strengthen programs that serve over 2.2 million American Indians and Alaska Natives at over 650 health care facilities across the United States. The request fully funds estimated Contract Support Costs in FY 2016 and proposes to modify the program in FY 2017 by reclassifying it as a mandatory appropriation, creating a longer-term solution.

Bolstering the Nation's Health Workforce. The Budget includes a $14.2 billion investment in our Nation's health care workforce to improve access to health care services, particularly in rural and other underserved communities. That includes support for over 15,000 National Health Service Corps clinicians, who will serve the primary care, mental health, and dental needs of nearly 16 million patients in high-need areas across the country. The Budget also creates new funding for graduate medical education in primary care and other high-need specialties, which will support more than 13,000 residents over 10 years, and advance the Administration's goal of higher-value healthcare that reduces long-term costs.

To continue encouraging provider participation in Medicaid, the Budget invests $6.3 billion to extend the enhanced Medicaid reimbursement rate for primary care services, and makes strategic investments to encourage primary care by expanding eligibility to obstetricians, gynecologists, and non-physician practitioners. A January 2015 study by University of Pennsylvania and Urban Institute researchers found that the share of Medicaid enrollees who successfully got appointments with primary care providers grew by nearly 8 percentage points between 2012 and 2014, when the program was fully implemented. The Budget also supports the provision of primary care services in the Medicare program by permanently incorporating the temporary 10 percent primary care incentive payment program into the Medicare physician fee schedule.

Investing in Health Centers. Health centers are an essential primary care provider for America's most vulnerable populations, serving 1 out of every 15 Americans while reducing the use of costlier care through emergency departments and hospitals. The Budget includes $4.2 billion for health centers, including $2.7 billion in mandatory resources, to serve approximately 28.6 million patients in FY 2016 at more than 9,000 sites in medically underserved communities throughout the country.

The Department's requests for health centers and the National Health Service Corps are vitally important, as the existing mandatory funding streams for these programs end in 2015. Without renewed funding in 2016 and beyond, millions of Americans may lose access to essential cost-effective primary care services provided through our Nation's health centers, and efforts to ensure provider access in underserved rural and urban areas across the country through the National Health Service Corps will come to a halt.

DELIVERING BETTER CARE AND SPENDING OUR HEALTH CARE DOLLARS WISELY

If we find better ways to deliver care, pay providers, and distribute information, we can receive better care and spend our dollars more wisely, all the while supporting healthier communities and a stronger economy. To build on and drive progress on these priorities, we are focused on the following three key areas:

Improving the Way Care is Delivered. The Administration is focused on improving the coordination and integration of health care, engaging patients more fully in decision-making, and improving the health of patients—with an emphasis on prevention and wellness. HHS believes that incentivizing the provision of preventive and primary care services will improve the health and well-being of patients and slow cost growth over the long run through avoided hospitalizations and additional office visits. The Administration's efforts around patient safety and quality have made a difference—reducing hospital readmissions in Medicare by nearly eight percent, translating into 150,000 fewer readmissions between January 2012 and December 2013 and reducing hospital patient harm by 17 percent from 2010 to 2013, saving 50,000 lives and $12 billion in health spending according to preliminary estimates.

Improving the Way Providers are Paid. The Administration is testing and implementing new payment models that reward value and care coordination—rather than volume. HHS has seen promising results on cost savings with alternative payment models: already, existing Accountable Care Organizations (ACOs) programs have generated combined total program savings of $417 million to Medicare. To shift Medicare reimbursement from volume to value, and further drive progress in the health care system at large, the Department has announced its goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models by 2016 and 50 percent by 2018.

The Budget supports progress in this area by including proposals targeted at changing provider incentives and payment mechanisms. For example, the Budget puts Medicare's payments to physicians on solid ground by replacing Medicare's flawed Sustainable Growth Rate formula. The Budget would establish new annual physician payment updates to provide certainty and consistency to providers; create incentives for providers to participate in proven alternative payment models like ACOs; and streamline other value-based incentives. The Administration supports a long-term policy solution to fix the SGR and applauds the bipartisan, bicameral efforts that Congress undertook last year. The Administration looks forward to working with Congress to build on that effort and reform Medicare physician payments in a fiscally responsible manner.

Improving the Way Information is Distributed. The Administration is working to create transparency of cost and quality information and to bring electronic health information to the point of care—enabling patients and providers to make the right decisions at the right time to improve health and care. The Centers for Medicare and Medicaid Services (CMS) is making major strides to expand and improve its provider compare websites, which empower consumers with information to make more informed health care decisions, encourage providers to strive for higher levels of quality, and drive overall health system improvement. To improve communication and enhance care coordination for patients, the FY 2016 Budget also includes a substantial investment ($92 million) in efforts supporting the adoption, interoperability, and meaningful use of electronic health records.

LEADING THE WORLD IN SCIENCE AND INNOVATION

Investments in science and innovation have reshaped our understanding of health and disease, advanced life-saving vaccines and treatments, and helped millions of Americans live longer, healthier lives. With the support of Congress, there is more that we can do together. The President's FY 2016 Budget request lays the foundation to maintain our Nation's global edge in medical research. This Budget for NIH supports ongoing research and provides real investments in innovative science.

Advancing Precision Medicine. The FY 2016 Budget includes $215 million for the Precision Medicine Initiative, a new cross-Department effort focused on developing treatments, diagnostics, and prevention strategies tailored to the genetic characteristics of individual patients. This effort includes $200 million for the National Institutes of Health (NIH) to launch a national research cohort of a million or more Americans who volunteer to share their information, including genetic, clinical and other data to improve research, as well as to invest in expanding current cancer genomics research, and initiating new studies on how a tumor's DNA can inform prognosis and treatment choices. The Department will also modernize the regulatory framework to aid the development and use of molecular diagnostics, and develop technology and define standards to enable the exchange of data, while ensuring that appropriate privacy protections are in place. With the support of Congress, this funding would allow the Department to scale up the initial successes we have seen to date and bring us closer to curing the chronic and terminal diseases that impact millions of Americans across the country.

Supporting Biomedical Research. The FY 2016 Budget includes $31.3 billion for NIH, an increase of $1 billion over FY 2015, to advance basic biomedical and behavioral research, harness data and technology for real-world health outcomes, and prepare a diverse and talented biomedical research workforce. This research is critical to maintaining our country's leadership in the innovation economy, and can result in life-changing breakthroughs for patients and communities. For example, that NIH estimates it will be able to spend $638 million under this Budget request on Alzheimer's research, an increase of $51 million over FY 2015, which will position us to drive progress on recent advances in our understanding of the genetics and biology of the disease, including drugs currently in clinical trials, and those still in the pipeline.

ENSURING THE BUILDING BLOCKS FOR SUCCESS AT EVERY STAGE OF LIFE

As part of the President's plan to bolster and expand the middle class, the Budget includes a number of proposals that help working Americans meet the needs of their families—including young children and aging parents.

Investing in Early Learning. High-quality early learning opportunities both promote children's healthy development and support parents who are balancing work and family obligations. Across the United States, many American families face real difficulties finding and affording quality child care and early education. In 2013, the average cost of full-time care for an infant at a child care center was about $10,000 per year—higher than the average cost of in-state tuition and fees at a public 4-year college. The Budget outlines an ambitious plan to make affordable, quality child care available to every low-income and middle-class family with young children; to expand access to high-quality early learning opportunities through the Head Start and Early Head Start programs; and to invest in voluntary, evidence-based home visiting programs that have been shown to leave long-lasting, positive impacts on parenting skills, children's development, and school readiness. These investments complement proposals at the Department of Education to provide high-quality Preschool to all four year olds from low- and moderate-income families and expand programs for middle-class children as well.

The President's child care proposal builds on the reforms passed by Congress in the bipartisan reauthorization of the Child Care and Development Block Grant enacted last fall. The proposal makes a landmark investment of an additional $82 billion over 10 years in the Child Care and Development Fund (CCDF), which by 2025 would expand access to more than 1 million additional children under age four, reaching a total of more than 2.6 million children. At the same time, the proposal provides resources to help states raise the bar on quality, and design programs that better serve families facing unique challenges in finding quality care, such as those in rural areas or working non-traditional hours.

The Budget includes an additional $1.5 billion above FY 2015 to improve the quality of Head Start services and expand access to Early Head Start, including through Early Head Start—Child Care Partnerships. The proposal will ensure that all Head Start programs provide services for a full day and full-school year and increase the number of infants and toddlers served in high-quality early learning programs. It will also ensure that program funding keeps pace with inflation and that the program can restore enrollment back to the 2014 level.

The Budget also proposes $15 billion over ten years to extend and expand access to evidence-based home visiting programs building on research showing that home visits by a nurse, social worker, or other professional during pregnancy and in the early years of life can significantly reduce child abuse and neglect, improve parenting, and promote child development and school readiness.

Research by the President's Council of Economic Advisors indicates that investments in high-quality early education generate economic returns of over $8 for every $1 spent. Not only that, studies show high-quality early learning programs result in better outcomes for children across the board—with children more likely to do well in school, find good jobs and greater earnings, and have fewer interactions with the criminal justice system. These programs also strengthen parents' abilities to go to work, advance their career, and increase their earnings. That is why the Administration has outlined a series of measures, including tax cuts for working families, to advance our focus on improving quality, while also dramatically expanding access.

Supporting Older Adults. The number of older Americans age 65 and older with severe disabilities—defined as 3 or more limitations in activities of daily living—that are at greatest risk of nursing home admission, is projected to increase by more than 20 percent by the year 2020. With 2015 marking the year of the White House Conference on Aging, the Department's Budget request makes investments to address the needs of older Americans, many of whom require some level of assistance to continue living independently or semi-independently within their communities. The Budget includes common-sense reforms that help to protect older Americans from identity theft, while supporting family caregivers and expanding options for home and community-based services and supports.

Improving Child Welfare. The Department's Budget also proposes several improvements to child welfare programs that serve children who have been abused and neglected or are at risk of maltreatment. The Budget includes a proposal that has generated bipartisan interest that would provide $750 million over five years

for an innovative collaboration between the Administration for Children and Families (ACF) and CMS that would assist states to provide evidence-based interventions to youth in the foster care system to reduce the over-prescription of psychotropic medications. There is an urgent need for action: ACF data show that 18 percent of the approximately 400,000 children in foster care were taking one or more psychotropic medications at the time they were surveyed. It also requests $587 million over ten years in additional funding for prevention and post-permanency services for children in foster care, most of which must be evidence-based or evidence-informed. It includes savings of $69 million over ten years to promote family-based foster care for children with behavioral and mental health needs, as an alternative to congregate care, and provides increased oversight of congregate care when such placements are determined to be necessary.

KEEPING AMERICANS HEALTHY

The President's FY 2016 Budget strengthens our public health infrastructure, invests in behavioral health services, and prioritizes other critical health issues.

Investing in Domestic and International Public Health Preparedness. The health of people overseas directly affects America's safety and prosperity, with far-reaching implications for economic security, trade, the stability of foreign governments, and the well-being of U.S. citizens abroad and at home. The Budget includes $975 million for domestic and international public health preparedness infrastructure, including an increase of $12 million for Global Health Security Agenda implementation to build the capacity for countries to detect and respond to potential disease outbreaks or public health emergencies and prevent the spread of disease across borders.

As new infectious diseases and public health threats emerge, HHS continues to invest in efforts to bolster the Nation's preparedness against chemical, biological, nuclear, and radiological threats. This includes a $391 million increase for Project BioShield to support procurements and replenishments of new and existing countermeasures and to advance final stage development of new products, and to replace expiring countermeasures and maintain current preparedness levels in the Strategic National Stockpile.

Combatting Antibiotic Resistant Bacteria. The Centers for Disease Control and Prevention estimates that each year at least two million illnesses and 23,000 deaths are caused by antibiotic-resistant bacteria in the United States alone. The Budget nearly doubles the amount of federal funding for combating and preventing antibiotic resistance within HHS to more than $990 million. The funding will improve antibiotic stewardship; strengthen antibiotic resistance risk assessment, surveillance, and reporting capabilities; and drive research innovation in the human health and agricultural sectors.

Addressing Prescription Drug and Opioid Misuse and Abuse. The misuse and abuse of prescription drugs impacts the lives of millions of Americans across the country, and costs the American economy tens of billions of dollars in lost productivity and increased health care and criminal justice expenses. In 2009, total drug overdoses overtook every other cause of injury death in the United States, outnumbering fatalities from car crashes for the first time. In 2012 alone, 259 million opioid prescriptions were written—enough for every American adult to have a bottle. As part of a new, aggressive, multi-pronged initiative, the Budget includes more than $99 million in new funding this year in targeted efforts to reduce the prevalence and impact of opioid use disorders. The Budget also includes improvements in Medicare and Medicaid, including a proposal to require states to track high prescribers and utilizers of prescription drugs in Medicaid, which would save $710 million over 10 years and bolster other efforts to reduce abuse of prescription drugs.

LEAVING THE DEPARTMENT STRONGER

The FY 2016 Budget request positions the Department to most effectively fulfill our core mission by investing in a number of key management priorities that will strengthen our ability to combat fraud, waste, and abuse, strengthen program integrity, and enable ongoing cybersecurity efforts, among other areas.

Strengthening Program Integrity. The FY 2016 Budget continues to build on progress made by the Administration to eliminate excess payments and fraud. The Budget includes new investments in program integrity totaling $201 million in FY 2016 and $4.6 billion over ten years. This includes, for example, the continued funding of comprehensive efforts to combat health care fraud, waste, and abuse through prevention activities, improper payment reductions, provider education, audits and

investigations, and enforcement through the full Health Care Fraud and Abuse Control (HCFAC) discretionary cap adjustment. This investment builds on important gains over the course of the past several years: from 2009 to 2013, programs supported by HCFAC have returned over $19 billion in health care fraud related payments. Together, the Department's proposed program integrity investments will yield $22 billion in gross savings for Medicare and Medicaid over 10 years.

Reforming the Medicare Appeals Process. Between FY 2009 and FY 2014, the number of appeals received by the Office of Medicare Hearings and Appeals has increased by more than 1300%, which has led to a backlog that is projected to reach 1 million appeals by the end of FY 2015. The Department has undertaken a three-pronged strategy to improve the Medicare Appeals process: (1) Take administrative actions to reduce the number of pending appeals and prevent new cases from entering the system; (2) Request new resources to invest at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog; and (3) Propose legislative reforms that provide additional funding and new authorities to address the appeals volume. The FY 2016 Budget includes a comprehensive legislative package of seven proposals aimed both at helping HHS process a greater number of appeals and reducing the number of appeals filed and requests additional resources for CMS, OMHA, and the Departmental Appeals Board to enhance their capacity to process appeals.

CONCLUSION

Members of the Committee, thank you for the opportunity to testify today. The President's FY 2016 Budget request for HHS makes the investments critical for today while laying the foundation for a stronger economy for the middle class. I am looking forward to working closely with Congress and Members of this Committee on these priorities moving forward so that together we can best deliver impact for those we serve—the American people. I welcome any questions you may have.

QUESTIONS SUBMITTED FOR THE RECORD TO HON. SYLVIA MATHEWS BURWELL

QUESTIONS SUBMITTED BY HON. ORRIN G. HATCH

MEDICAID

Question. As the Medicaid program has grown, so too has the need for more accurate data on Medicaid spending, payments, and utilization. Today, Medicaid is the largest insurer in the nation, serving more than 20 percent of the nation's population. Nonetheless, accurate and timely information about spending, provider payments, and beneficiaries' utilization is not available. This is unacceptable and CMS has been working to improve this situation for years but with limited success. More recently, CMS has established enhanced matching funds and grants to states to develop the Transformed-Medicaid Statistical Information System (T–MSIS), the primary source of national information on Medicaid utilization and provider payments. According to CMS, this data system is supposed to be getting monthly data feeds from all states by the end of 2015.

How much federal funding is allocated to Medicaid information system development and maintenance and how does this compare to federal funding for the Medicare program?

Answer. The total FY 2014 federal match for state MMIS was $4.3 billion. In addition to the federal match for state claims systems, CMS allocated $20.2 million to T–MSIS development and maintenance in FY 2014. Federal funding is allocated to a variety of information systems at both the state and federal level, and Medicaid is a state-federal partnership. This makes it difficult to provide a Medicare system funding number that is at all comparable with the aggregate spending on Medicaid systems. Specifically, Medicaid claims systems include state Medicaid Management Information Systems (MMIS) and the federal Medicaid Statistical Information System (MSIS), which is being updated and modernized as part of the Medicaid and CHIP Business Information Solutions (MACBIS) initiative to become the Transformed-MSIS (T–MSIS).

Question. Please provide a breakdown of the Medicaid budget for activities within CMS, for federal contractors, and for each state. Is this funding adequate to bring all states into compliance with most of the T–MSIS reporting requirements?

Answer. The $20.2 million in FY 2014 for CMS to develop and maintain T–MSIS went entirely to federal contractors, including $4 million for a contractor providing technical assistance to states as states work to come into compliance with T–MSIS reporting requirements. This technical assistance was available to all states. We anticipate the need for continued expenditures on MACBIS as states transition to T–MSIS over the coming years. To this end, the FY 2016 President's Budget requests $4 million in CMS Program Management for maintenance of MACBIS systems.

Question. The federal Medicaid statute affords states considerable flexibility both in how they finance their Medicaid programs and in how they pay providers. Health care related taxes on providers and intergovernmental transfers are commonly used by states to finance their share of Medicaid expenditures, yet information on the taxes and governmental transfers is not systematically collected by CMS. Provider taxes effectively reduce Net Medicaid payments to providers. In addition, states often make lump-sum supplemental payments, commonly referred to as non-DSH supplemental payments to certain providers that increase providers' compensation to the maximum federal upper limit (FUL), thereby qualifying for additional federal matched dollars. Some providers receive as much as 50 percent of their payments from non-DSH supplemental payments. However, these payments are not reported to the federal government in a consistent or useable format. Without data on both health care related taxes and supplemental payments, we do not know how much we are paying providers, how much we are spending for Medicaid services, we cannot assess payment adequacy or the relationship between payment and important outcomes. Further, without this key information, the program is vulnerable to fraud and abuse.

What initiatives, if any, has CMS taken to collect this information? Are there particular obstacles in collecting this information?

Answer. We take our responsibility for oversight and federal stewardship of the Medicaid program very seriously, including requiring that states correctly report their Medicaid expenditures so that we can ensure Federal Medicaid funds are appropriately spent. In 2013, to improve transparency into supplemental payments, CMS began requiring states to submit upper payment limit (UPL) documentation on an annual basis, allowing CMS and states to have a better understanding of the variation in rate levels, supplemental payments, total providers participating in the programs, and the funding supporting each of the payments described in the UPL documentation.

Question. What steps are you taking to ensure that your agency Administrators are addressing and coordinating on an ongoing basis on issues and programs that intersect?

Answer. The complex issues the Department deals with often cross Agency boundaries. The Department takes coordination very seriously. The Department has many mechanisms to encourage coordination on its cross-cutting issues and programs, and has internal processes to ensure that public documents fully reflect the views of the Department and not individual agencies. Some of these are formal and of long-standing. For example, for almost twenty years, the Department's Data Council, co-chaired by officials from the Agency for Healthcare Research and Quality and the Office of the Assistant Secretary for Planning and Evaluation, has coordinated data policy for the Department and its agencies through regular meetings, shared work products, and coordinated data policy.

Other groups are established to draw and share expertise from across the Department on issues of current concern. One such example is a trans-HHS taskforce, the Healthy Weight, Nutrition and Physical Activity (HWNPA) workgroup. This group is convened by the Office of the Assistant Secretary for Health and allows Agency representatives to share information on their activities addressing issues such as school nutrition, childhood obesity, healthy weight measures, and walking and walkability. As part of the annual budget process, HHS reviews all programs to eliminate duplicative activities either by eliminating programs or changing the scope of a program.

Every quarter, our agencies meet to discuss the HHS high priority goals, for example, eliminating healthcare associated infections (HAIs) and reducing the use of tobacco products, that involve many HHS agencies. These meetings foster communication and ensure that HHS efforts are coordinated. For example, AHRQ has developed best practices for health care providers to reduce HAIs, CDC monitors the prevalence of HAIs, and CMS distributes best practice information to providers.

Regular meetings ensure that efforts are not duplicated but rather that each agency's efforts supports the efforts of its fellow agencies.

For the second time this year, HHS will undertake a review of its twenty-one strategic objectives and grade itself on our success meeting those objectives. Part of that process will focus on coordination and duplication and those assessments will be publically available.

Question. Specifically, with regard to Medicaid, there are financing, quality of care and program integrity issues that providers and public entities have identified as duplicative and sometimes conflicting (e.g. with FQHCs and Medicaid, with 340B entities and Medicaid, with SAMHSA funded entities and Medicaid funding streams including the new Sec. 223 behavioral health clinics, privacy regulations that prevent care coordination, etc.). From among these, what are you as the Secretary prioritizing?

Answer. As HHS operates, improves and modernizes existing programs, we always strive to ensure that these programs work in coordination with programs within our Agencies and throughout the Department. We will continue to strive for continuous improvement making the programs we steward work better for the people they serve while consistently improving their efficiency.

For example, in April 2014, the Protecting Access to Medicare Act was signed into law, funding a demonstration program to allow eight participating states to make payments to Certified Community Behavioral Health Clinics based on a prospective payment system. The goal of the demonstration is to expand access to community mental health services and strengthen the quality of care offered at those centers. CMS has been focused on working collaboratively with other agencies to implement this important program. While CMS is responsible for determining the details of the payment system, SAMHSA is responsible for setting the criteria that clinics will have to meet to be eligible for the demonstration program, and ASPE is helping with both of those components as well as with designing the evaluation of the demonstration. CMS is also working with SAMHSA and other HHS partners to incorporate comments received on draft criteria published for comment in February 2015 to ensure coordination of federal guidance.

Question. How is the Department managing other issues on an ongoing basis to ensure the integrity of the Medicaid program?

Answer. States and the Federal Government share mutual obligations and accountability for the integrity of the Medicaid program and the development, application and improvement of program safeguards necessary to ensure proper and appropriate use of both Federal and state dollars.

This Federal-state partnership is central to the success of the Medicaid program, but it depends on clear lines of responsibility and shared expectations. We take seriously our role in overseeing the financing of states' Medicaid programs, and we continue to look for ways to refine and further improve our processes.

Medicaid is currently undergoing significant change as CMS and states implement reforms to modernize and strengthen the program and its services. While focused on implementation of the Affordable Care Act, CMS has been working closely with states to implement delivery system and payment reforms. CMS has encouraged state efforts with new tools and strategies to improve the quality of care and health outcomes for beneficiaries and to promote efficiency and cost effectiveness in Medicaid. And, as always, CMS works to ensure appropriate financial management mechanisms are in place to ensure dollars are spent appropriately.

Question. What, if any, role have state Medicaid agencies or states more generally had in the new Medicare Health Care Payment and Innovation Network? Can you describe how the Department plans to incorporate them going forward?

Answer. In January 2015, HHS announced the creation of the Health Care Payment Learning and Action Network. The Health Care Payment Learning and Action Network ("Network") is being established to provide a forum for public-private partnerships to help the U.S. health care system (both private and public) meet or exceed recently established Medicare goals for value-based payments and alternative payment models. To help drive the health care system towards greater value-based purchasing—rather than continuing to reward volume regardless of quality of care delivered, HHS has set a goal of moving 30 percent of Medicare payments into alternative payment models by the end of 2016 and 50 percent into alternative payment models by the end of 2018. Alternative payment models include models such as Accountable Care Organizations (ACOs), bundled payments, and advanced primary

care medical homes. Overall, HHS seeks to have 85 percent of all traditional Medicare payments tied to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.

States and state Medicaid agencies are critical partners in this effort. Engagement with state Medicaid programs and commercial payers can help increase alignment, reduce burden on providers, and accelerate progress to deliver higher quality care. The first meeting of the Network will be held on Wednesday, March 25th, and we expect significant participation from both entities. For example, we expect Governor Jack Markell of Delaware to participate in the event and announce goals for the state of Delaware to move their health care system towards rewarding quality over quantity.

Question. How is HHS/CMS planning to work with states to advance community integration initiatives and balancing competing priorities given limited state and federal resources?

Answer. Many states choose to provide home and community-based alternatives to institutional care to allow Medicaid beneficiaries to receive services in the most integrated setting. The Centers for Medicare and Medicaid Services (CMS) works with these states to ensure beneficiaries receive long-term services and supports (LTSS) in settings that are integrated in and support full access to the greater community. In addition, CMS administers the Money Follows the Person and Balancing Incentive grant programs to provide participating states additional resources to assist in rebalancing their LTSS systems to transition Medicaid beneficiaries from institutions to the community.

Question. Does CMS require specific new authority to support states that seek to improve Medicare and Medicaid coordination using the Medicare Advantage Duals Special Needs Plans? If not, what have you done to accomplish this to date and what are your plans for doing so? What are the barriers to aligning traditional MA, MA–DSNPs and Medicaid?

Answer. The President's budget includes two specific recommendations for legislative authority that would allow CMS and its state partners to improve Medicare and Medicare coordination through D–SNPs. The first recommendation would provide the Secretary of HHS the authority to implement an integrated appeals system for Medicare-Medicaid enrollees of health plans that integrate Medicare and Medicaid benefits, such as D–SNPs. This legislative proposal was also included in the President's Budget for Fiscal Year 2015 and the FY2013 Report to Congress from the CMS Medicare-Medicaid Coordination Office. The second recommendation would provide CMS and states the ability to perform cooperative reviews of D–SNP marketing materials for compatibility with a unified set of standards, reducing the burden on CMS, the states, and plans, and resulting in a more uniform message to Medicare-Medicaid enrollees.

States that seek to improve Medicare and Medicaid coordination using the Medicare Advantage Duals Special Needs Plans (D–SNPs) can structure their State Medicaid Agency Contracts—required by all D–SNPs—to encourage better integration, and may require full integration of Medicare and Medicaid services under a single Medicare Advantage Organization. CMS has worked with a number of States seeking to move toward higher integration of their D–SNPs on how best to structure their State Medicaid Agency Contracts.

We are working to extend administrative flexibilities to D–SNPs that meet a high standard for integration of Medicare and Medicaid benefits with a particular focus on:

- Development of materials that better communicate the integrated benefit to the Medicare-Medicaid enrollee population, including materials in alternative formats and languages other than English for Medicare-Medicaid enrollees who require such materials;
- Enhanced coordination of state and CMS regulatory oversight; and
- Integration of state quality-of-care priorities into the care delivery provided by highly integrated D–SNPs.

Of note is that under current CMS requirements, all D–SNPs must meet the same requirements applicable to all Medicare Advantage plans, regardless of the level of integration.

Question. Congress has passed statutory language related to provider enrollment issues. CMS has indicated that it is also focusing resources on this issue. What barriers (policy and/or systems) are you encountering to streamline and improve efficiencies for processes within and between Medicare and Medicaid?

Answer. In 2014, CMS finalized rules that strengthen oversight of Medicare providers and suppliers and protect taxpayer dollars from bad actors. These new safeguards are designed to prevent physicians and other providers and suppliers with unpaid debt from re-entering Medicare, remove providers and suppliers with patterns or practices of abusive billing, and implement other provisions to help save more than $327 million annually. Authorized by the Affordable Care Act and by provisions in the Social Security Act, the new changes allow CMS to:

- Deny enrollment to providers, suppliers and owners affiliated with any entity that has unpaid Medicare debt; this will prevent people and entities that have incurred substantial Medicare debts from exiting the program and then attempting to re-enroll as a new business to avoid repayment of the outstanding Medicare debt.
- Deny or revoke the enrollment of a provider or supplier if a managing employee has been convicted of a felony offense that CMS determines to be detrimental to the Medicare program and its beneficiaries. The recently implemented background checks will provide CMS with more information about felony convictions for high risk providers or suppliers.
- Revoke enrollments of providers and suppliers engaging in abuse of billing privileges who demonstrate a pattern or practice of billing for services that do not meet Medicare requirements.

In addition, state Medicaid agencies are required to deny enrollment or terminate the enrollment of any provider that is terminated on after January 1, 2011 under Medicare or, for cause, by other states' Medicaid (or CHIP) programs. CMS tools available to help states facilitate this requirement include the following:

- CMS has been providing states direct access to the Medicare provider enrollment system known as PECOS (Provider Enrollment, Chain, and Ownership System) since April 2012. This system enables states to review all current and historic information on each Medicare provider and supplier, including a National Provider Identifier, Taxpayer Identification Number, and legal business name. To increase efficiency and accessibility for states, CMS has been creating a regular data extract of key Medicare enrollment information since January 2013.
- In December 2013, CMS developed and launched an enhanced collection, storage, and delivery process for Medicaid termination notifications. A CMS system notifies state Medicaid agencies of terminations submitted by other state Medicaid and CHIP programs as well as all Medicare revocations.
- All states can request and gain access to the CMS Fraud Investigation Database (FID), which contains information on investigations, cases, and payment suspensions pertaining to Medicare providers. The database contains numerous searchable fields that can assist states in identifying problem providers who are enrolled in both Medicare and Medicaid.

Finally, the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) works to improve the coordination between the Federal Government and states to enhance access to quality services for individuals who are enrolled in both Medicare and Medicaid. Since 2011, the Medicare-Medicaid Coordination Office has undertaken the Alignment Initiative, which has served as CMS' guide for streamlining Medicare and Medicaid program rules, requirements, and policies. Department and CMS-wide Medicare-Medicaid workgroups have been formed to work on the opportunities for alignment identified through the Alignment Initiative, which have included provider requirements.

MEDICARE ADVANTAGE AND PART D

Question. The Medicare Advantage and Part D programs have continued to grow since their inception, and are expected to continue that growth and represent an increasing proportion of the Medicare population. However, funding for important program integrity and audit activities for these programs does not reflect an equitable and appropriate distribution of funds.

In the FY 2015 HCFAC (Health Care Fraud and Abuse Control) program budget, approximately $9 million was budgeted for audit, oversight and enforcement of Medicare Advantage and Part D sponsors. Meanwhile, approximately 30 percent of all Medicare eligible beneficiaries are enrolled in the Medicare Advantage program, and approximately 70 percent are enrolled in Part D. My understanding is that with the current level of funding, it will take approximately *seven years* for CMS to complete audits of all Medicare Advantage and Part D sponsors.

Can you tell me what amount of money is budgeted for this important work in FY 2016?

Answer. The FY 2016 President's Budget includes a request for $184.9 million in HCFAC discretionary funding for Medicare Parts C and D oversight and program integrity activities. This funding will strengthen Medicare Parts C and D efforts by the Medicare Drug Integrity Contractors to proactively fight fraud; improve safeguards that ensure the accuracy of payments to Medicare Advantage Organizations and Part D Prescription Drug Plans; and invest in additional program, compliance, and risk adjustment data validation (RADV) audits, and system updates for our contracting and plan oversight efforts.

Question. Do you think this amount of funding is sufficient for oversight of these important programs?

Answer. The HCFAC funding requested in the President's Budget is consistent with the level included in the Consolidated and Further Continuing Appropriations Act, 2015, with the full cap adjustment included in the Budget Control Act of 2011. With the full discretionary HCFAC cap adjustment funding, requested in FY 2016, CMS will be able to fully support Medicare Parts C and D activities to fight fraud, waste, and abuse, and invest in additional audits and system updates to our contracting and plan oversight efforts.

MEDICARE ALTERNATIVE PAYMENT MODELS/
CENTER FOR MEDICARE AND MEDICAID INNOVATION

Question. Just last week, HHS announced plans to dramatically increase the percentage of Medicare payments made under alternative payment models to 50 percent by 2018. I'm concerned about going down this path too quickly when we know there are risks to beneficiaries and the evidence on their results is limited. In the 4 years that the CMS Innovation Center has been testing alternative payment models, we haven't seen many evaluation reports, and of the programs that CMS has evaluated so far, results are mixed at best.

Do you agree that we need to fully understand the implications of alternative payment models on patient access and quality of care before encouraging greater participation in these models?

Answer. We are taking action to build on progress made in improving health care so patients and their families can get the best care possible. Our goal is to spend our health care dollars more wisely, so—ultimately—people can live healthier lives. To achieve better care, smarter spending and healthier people, we are focused on three key areas: (1) improving the way providers are paid, (2) improving and innovating in care delivery, and (3) sharing information more broadly to providers, consumers, and others to support better decisions while maintaining privacy.

In support of the alternative payment model goals, we are testing a variety of models at a sufficiently large scale to produce valid data on results, to understand the dynamics of how a model might operate under a variety of market circumstances and also to foster and encourage a climate of innovation and quality improvement within the provider community. So that we fully understand the implications of our efforts, we conduct a robust evaluation of all of our models on an ongoing basis throughout the life of the model. In every model evaluation, we strive to determine the impact of the innovation on patient and provider experiences, outcomes and quality of care, and program expenditures. We make sure that our models are well designed—and we use all appropriate scientific and statistical methods to study the impact of the model test relative to what would have happened in the absence of that model test. We study these results carefully in making decisions about models.

Question. The CMS Innovation Center Bundled Payments for Care Improvement (BPCI) Initiative—which pays providers a single "bundled" payment for hospital and/or post hospital service—is the largest initiative undertaken by the CMS Inno-

vation Center. Yet, as of October last year, over 95 percent of the participants in the program are not currently receiving bundled payments.

Why are so few BPCI participants currently receiving bundled payments?

Answer. Applicants had two opportunities to enter the Bundled Payments for Care Improvement (BPCI) initiative. Once screened, interested organizations entered into Phase 1 of the models 2, 3 or 4 of BPCI. We had more than 890 participants enter Phase 1 over the course of this initiative between January 2013 and April 2014. Phase 1 Participants do not receive bundled payments. They receive baseline and monthly claims data that will help participants determine the clinical episodes for which they see an opportunity for care redesign. Phase 1 is also the preparatory stage of the initiative during which CMS works with participants and their partners through education and shared learning activities to prepare for transition to Phase 2, which is the risk bearing stage of BPCI. In Phase 2, participants are financially responsible to Medicare if their expenditures are higher than a target price established by Medicare for the episode(s) in which they are participating. Participants in Phase 2 sign an agreement with CMS and begin receiving bundled payments. Participants began entering Phase 2 in October of 2013. As of January 26, 2015 there are 105 participants in phase 2 of BPCI. We expect more organizations to enter Phase 2 in July at which time the opportunity to participate in Phase 1 will end. As more participants enter Phase 2, the number of awardees receiving bundled payments will increase.

Question. The Bundled Payment for Care Improvement Initiative also does not tie provider payment to patient quality of care—what is the agency doing to protect patients treated by providers participating in this initiative?

Answer. CMS protects beneficiaries treated by BPCI awardees in a number of ways. BPCI awardees that have an agreement with CMS are required to submit their approach to care redesign and quality performance targets to CMS for approval. CMS conducts reviews to make certain BPCI awardees are in compliance with their care redesign methods.

We continually monitor patient quality of care. All sites participating in BPCI are required to submit extensive quality related data to CMS for evaluation. This data includes participant baseline characteristics (i.e. patient case mix, payment incentives experiences, health information exchange), quality monitoring measures (i.e. medication reconciliation at admission and discharge, patient death or serious injuries reportable to the FDA, etc.), and status of care redesign. Participants must comply with all relevant quality reporting and incentive programs for providers enrolled in Medicare. In addition, beneficiaries may call 1–800–Medicare with any questions or speak to their physicians about the initiative.

Question. To encourage greater provider participation in the bundled payments, has CMS considered adjusting the BPCI to build in protections for providers treating patients who need specialized treatment?

Answer. Making certain that our beneficiaries receive high quality health care—and that the quality of their care improves over time—is one of our most important goals. CMS does make adjustments in BPCI that mitigate provider financial risk for certain unrelated services. CMS also mitigates financial risk for extreme levels of expenditure that could occur during an episode of care. These policies help in making sure that patients in BPCI will get any type of treatment that they need.

For example, CMS maintains and updates lists of services that are excluded from BPCI Clinical Episodes in Models 2-4 for both Part A and Part B services. Services that are considered unrelated are not included in the episode and the provider or supplier will receive normal Fee-for-Service (FFS) payment. These lists are updated periodically and include things like heart transplants and hemophilic clotting factors.

With regard to extreme levels of expenditure, BPCI participants in Models 2 and 3 also have the discretion to choose three different episode durations and three different risk tracks on a quarterly basis. Depending on the selected risk track, BPCI participants bear 100 percent financial risk up to a certain threshold and then are liable for only 20 percent of all spending beyond the threshold. This mitigates financial risk for episode expenditures above the upper threshold while still providing an incentive for the provider to provide services efficiently for beneficiaries with high episode expenditures.

Question. The CMS Innovation Center is charged with testing "innovative payment and service delivery models to reduce program expenditures . . . while pre-

serving or enhancing the quality of care" in federal health care programs. Yet, many of the measures the Innovation Center is intending to use to monitor quality of care focus on the amount of health services patients receive, not the effect those services have on patient health.

If reducing health services is being used as a proxy for quality of care, how can we be certain that providers are not stinting on care in an effort to meet CMS's measures?

Answer. Making certain that our beneficiaries receive high quality health care—and that the quality of their care improves over time—is one of our most important goals. For each model that CMS tests, CMS includes a monitoring and evaluation effort to address issues of patient protection and safety, including continual assessment of quality of care. We monitor for issues related to patient safety, care stinting and patient access to care, patient freedom of choice, and provider induced demand for unnecessary care. The monitoring approach is multipronged and utilizes a variety of measures and data sources depending on the specifics of the model. We use measures that provide information on patient case-mix, clinical process and outcomes, utilization patterns, and patient reported experience of care. Information comes from a variety of sources including claims, patient and proxy interviews, patient assessment information, and in qualitative sources such as site visits and interviews. These findings are tracked, examined and reviewed on an ongoing basis, typically quarterly. These efforts would allow us to quickly identify potentially negative shifts in patterns of care, including stinting of care. The precise monitoring strategy adopted is tailored to the unique circumstances of every model. The choice of measures is a reflection of the possible provider behaviors that could result from the incentives being tested in that model.

Question. What is CMS doing to ensure that the quality of care provided to patients in alternative payment models is equivalent or better than that provided to patients in traditional Medicare?

Answer. Making certain that our beneficiaries receive high quality health care—and that the quality of their care improves over time—is one of our most important goals. CMS does this in two ways—real-time monitoring and rapid-cycle evaluation. First, each model has a monitoring strategy that is customized to the specific circumstances and model financial structure. Before launching a model, CMS carefully considers unintended consequences, such as care stinting, and designs monitoring strategies that actively check for such adverse outcomes. By receiving regular updates from 1–800–MEDICARE, a model team can quickly learn of any potential issues as they arise. Other monitoring strategies include: analysis of claims data to identify abnormal billing patterns, audits of participants, and analysis of EHR-based quality measures.

Second, every model has a rigorous, yet rapid-cycle, evaluation conducted by an independent team that unfolds concurrently with model implementation. A key component of each evaluation is measuring care quality. While each model is different and requires a customized evaluation approach, common components include: regular surveys of beneficiary experience of care, analysis of claims-based quality of care outcomes, and qualitative data collection, such as patient and caregiver focus groups. By conducting these activities as the model is implemented, the evaluation can quickly identify potential issues with care quality and allow CMS to take action.

Finally, Innovation Center models include incentives to provide more efficient and better quality care. For example, shared savings components of models generally require participants to meet or exceed quality benchmarks relative to traditional Medicare.

COMPETITIVE BIDDING PROGRAM—ENTERAL NUTRITION

Question. In the FY2015 omnibus appropriations bill, Congress requires CMS to conduct a study of the impact of the competitive bidding program. Specifically, the study is on enteral nutrition and requires CMS to submit a report within 90 days after enactment that assesses the impact of the program on changes in treatment patterns of enteral nutrition patients residing in skilled nursing facilities, nursing facilities, and intermediate care facilities, including the impact on the patient's health, whether access has been reduced, and if costs have increased due to new suppliers unfamiliar with the clinical demands associated with such care.

What is the status of this report?

Answer. CMS is currently reviewing initial findings from a data analysis contractor and is on track to submit this report later this spring.

BIOLOGICS AND BIOSIMILAR DRUGS

Question. As currently written, law requires payment for a biosimilar product to be the sum of the average sales price (ASP) of the biosimilar product plus 6 percent of the reference (innovator) biologic. However, there are payment ambiguities that the law does not address:

The law does not address coding for a biosimilar, which is a critical component of determining payment. Specifically, does CMS intend to assign a separate J-code for a biosimilar product?

Answer. CMS will address coding and payment for biosimilars later this year.

Question. The law does not address payment of multiple biosimilars. How will CMS pay a 2nd, 3rd, etc. biosimilar? Some interpret the law to say that the weighted average ASP of the biosimilars plus 6 percent of the reference biologic will be the payment for all of the biosimilars. Others read the law to say that the ASP of each biosimilar plus 6 percent of the reference biologic will be the rate for each biosimilar.

Answer. CMS is currently considering this question and expects to provide further guidance later this year.

Question. The payment structure in the law detailed above refers to a biosimilar product but not a biosimilar product that is interchangeable. What are CMS's views on basing the payment of a biosimilar product on the reference product for which it is not interchangeable as determined by the FDA? Is this the intent of the law? Is this sound policy?

Answer. CMS is currently considering the statutory basis for coding and payment of biosimilars and will provide further guidance later this year.

Question. Under current Medicare Part D rules, health plans are permitted to switch a patient who is stable on a biologic to another biologic without the consent of the physician or patient. The introduction of biosimilars on the market presents new safety concerns not envisioned by current Part D rules and requirements.

Does CMS intend to add safeguards to the Part D formulary requirements that protect patients who are stable on a biologic from being switched to a biosimilar that is not interchangeable?

Answer. Part D rules allow plans to consider requesting use of biosimilars instead of reference biological products. Under Part D rules, if a plan requests and is approved for a mid-year formulary change to substitute a biosimilar for the reference product, all beneficiaries currently receiving the reference product will continue to be able to receive that product for the remainder of the plan year. For new plan years, beneficiaries receiving a reference biological product who enroll in a plan that only lists the biosimilar will be eligible for a transition fill of the reference product and will have the right to request a formulary exception to continue on the reference product. The appeal process includes clinical factors that have been successfully applied since the initiation of the Part D program.

Question. Given the importance of interchangeability and other biosimilar-related matters, is CMS collaborating with FDA to ensure consistent interpretation and implementation of the law?

Answer. CMS regularly communicates with the FDA about drug related matters.

Question. FDA officials stated several times last year that we would see a number of pending guidance documents on biosimilars before the end of the year, including one on interchangeability, but we have not seen those and to date, we have four pending biosimilar applications before the Agency.

Can you please inform the Committee when we can expect to see guidance on interchangeability?

Answer. FDA has so far issued six draft guidances, all available on the FDA website. These documents give clear information on the requirements for biosimilars in terms of structure, safety, purity, potency, and other factors. We believe we have promptly and thoroughly analyzed and explained the requirements of the Act for all prospective manufacturers of biosimilar products; however, we will continually update these documents and issue additional guidances as needed.

With respect to interchangeability, FDA opened several dockets to solicit public comments on interchangeability of biosimilar products and is currently in the process of scientific review of these comments and developing the draft guidance. We understand the urgency of publishing this guidance and will do so as soon as possible.

Question. It now appears that in 2015 FDA will approve the first biosimilar drugs stemming from authority Congress provided in 2010.

What is the Department's estimate of impact of the introduction of biosimilars on government spending this year and over the next 5 and 10 years?

What are the unit cost and volume assumptions behind these estimates?

Does your estimate factor in added office visit and hospitalization costs that can be incurred when a stable patient is switched and has to be stabilized on the new drug?

Answer. The Department has not made an independent estimate of the impact of biosimilars on prescription drug spending in the U.S. The Department has closely monitored and reviewed estimates made by the Congressional Budget office and the experience with biosimilar products in Europe. In Table 1 below we summarize the estimates made by CBO. The most recent estimates (from 2008 and 2009) suggest that 10-year government savings stemming from the introduction of biosimilars will be in the range of $9.2 to $13 billion. As you will note the reports on those estimates do not include explicit volume assumptions. They also do not assume any costs of switching.

We have also been tracking the European experience with the introduction of biosimilar products. Recent research papers and published data suggest mixed experiences across Europe with respect to penetration rates for biosimilar products and price reductions linked to the competition they create. Germany, the UK and Sweden have had among the higher rates of biosimilar penetration and maybe instructive regarding potential savings in the U.S.[1] The penetration rate varies considerably by type of product. It can be as low as 9 percent to 18 percent or as high 55 percent to 73 percent in those nations. The price experience for biosimilars also ranges. Data for Germany, the UK and Sweden show biosimilar prices that are 16 percent to 55 percent below pre-biosimilar introduction prices. Grabowski and colleagues report price reductions on the order of 25 percent.[2]

For all of the reasons described above, modeling the potential cost impact of biosimilars is a complex task. We have been assessing evidence and closely monitoring the European experience with biosimilars in order to examine which of their evidence is most appropriate to use for theU.S. health care system. We also must carefully examine the extent to which current law and regulation which affects drug pricing under Medicare and Medicaid will potentially influence both price reductions for biosimilars and their market penetration.

TABLE 1—Government Projections for Biosimilars Savings

Source Name	CBO June 2008	CBO December 2008 (w/out Medicare Part B Payment Rate Modification)	CBO December 2008 (w/Medicare Part B Payment Rate Modification) *	CBO March 2009 (page 18)
Source Website	**	***	***	****
1-Year Timeline	2013	2010	2010	n/a
1-Year Government Savings (2013)	**$52 M**	**$100 M**	**$200 M**	**n/a**
5-Year Timeline	2009–2013	2010–2014	2010–2014	n/a

[1] IMS Institute, Assessing Biosimilar Uptake and Competition in European Markets, October 2014.

[2] Grabowski HG, R Guha and M Salgado (2014), Regulatory and Cost Barriers Are Likely to Limit Biosimilar Development and Expected Savings in the Near Future, Health Affairs 33(6):1048–1057.

TABLE 1—Government Projections for Biosimilars Savings—Continued

Source Name	CBO June 2008	CBO December 2008 (w/out Medicare Part B Payment Rate Modification)	CBO December 2008 (w/Medicare Part B Payment Rate Modification) *	CBO March 2009 (page 18)
5-Year Government Savings (2009–2013)	**$52 M**	**$100 M**	**$200 M**	**n/a**
10-Year Timeline	2009–2018	2010–2019	2010–2019	2009–2019
10-Year Government Savings (2009–2018)	**$6.6 B**	**$9.2 B**	**$12.2 B**	**$13 B**
Q2: Unit Cost and Volume Assumptions	n/a	n/a	n/a	n/a
Q3: Are Indirect Costs of Switching Factored into Estimate?	No	No	No	No

*Assumes the Medicare Part B payment system is modified to place the follow-on biologic in the same billing code as the original brand-name product.
** https://www.cbo.gov/sites/default/files/s1695.pdf.
*** http://www.cbo.gov/sites/default/files/12-18-healthoptions.pdf.
**** https://www.cbo.gov/sites/default/files/03-20-presidentbudget.pdf.

RACS AND IMPROPER PAYMENT

Question. The improper payment rate for Medicare has been increasing in recent years, from 8.6% in FY 2011 to 12.7% in FY 2014. At the same time, the entities charged with reducing improper payments, Medicare's recovery auditors, have seen their work curtailed in the past year.

What is CMS's plan to put the RACs back to work and bring the improper payment rate down going forward?

The RAC program seems to be an effective tool to fight against improper payments in the system.

Given that the error rate grew to 12.7% last year, how do we expand the RAC program to help lower the error rate?

Answer. HHS strives to manage programs in an efficient manner that balances the need to limit burden on Medicare providers with our responsibility to protect Trust Fund dollars. HHS has carefully evaluated the Recovery Audit program, and announced a number of changes to it in response to industry feedback.[3] HHS is confident that these changes will result in a more effective and efficient program through enhanced oversight, reduced provider burden, and more program transparency. These changes will be effective with each new contract award beginning with the Durable Medical Equipment, Home Health and Hospice Recovery Audit contract awarded on December 30, 2014.[4] The President's FY 2016 Budget also includes a proposal to permit HHS to retain a portion of recovered funds to implement corrective actions identified through the Recovery Audit program.

In all, Medicare receives about 3.3 million fee-for-service claims each day, or 1.2 billion claims a year. Due to the high number of claims, HHS is committed to paying claims in an accurate and timely manner and has a comprehensive strategy in place to address the Medicare improper payment rates. For the Medicare program, these strategies include strengthening provider enrollment safeguards to confirm only legitimate providers are enrolled and preventing improper payments by using edits to deny claims that should not be paid. HHS also develops targeted demonstrations in areas with consistently high rates of improper payments and, as your note, operates the Medicare fee-for-service Recovery Audit Program to identify, recover, and prevent improper payments.

The Recovery Audit Program identifies areas for potential improper payments and offers an opportunity to provide feedback to providers on future improper payment

[3] See *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf.*

[4] Due to a post-award protest filed at the Government Accountability Office (GAO), CMS has delayed the commencement of work under the national DMEPOS/HH&H, Region 5, Recovery Audit contract.

prevention. HHS uses Recovery Auditors, as required by law,[5] to identify and correct improper payments by reviewing claims on a post payment basis. HHS responds to the vulnerabilities identified by the Recovery Auditors by implementing actions that will prevent future improper payments nationwide. Since full implementation in FY 2010 through the fourth quarter of FY 2013, the Recovery Auditors have returned over $5.4 billion to the Medicare Trust Fund. Additionally, HHS Medicare Administrative Contractors (MACs) review claims and conduct provider education to help providers avoid documentation errors and other sources of improper payments, including articles or bulletins providing narrative descriptions of the claim errors identified and suggestions for their prevention. Other efforts include system edits for improper payments that can be automatically prevented prior to payment. HHS encourages collaboration between Recovery Auditors and MACs to discuss improvements, areas for possible review, and corrective actions that could prevent improper payments.

MEDICARE APPEALS BACKLOG

Question. The Administration recognizes the backlog in Medicare appeals as a problem and has set forth a series of legislative proposals to address it. Yet current policy is fueling large numbers of appeals—namely that ALJs are not bound by Medicare policy and certain ALJ's have been found by the Inspector General to rule with providers almost 100% of the time.

Do you agree the current system encourages providers to appeal frequently and contributes to the backlog?

Answer. The Department is committed to paying claims right the first time. However, we understand and respect the right of appeal. Administrative Law Judges (ALJs) administer the third level of Medicare appeals at the Office of Medicare Hearings and Appeals (OMHA). ALJs are bound to follow the same authorities that bind lower level adjudicators, with the exception of informal policy guidance and manuals which CMS may issue to its contractors. Although this leads to a common misperception that "Administrative Law Judges are not bound by Medicare policy," the current regulatory scheme does bind CMS Qualified Independent Contractors, ALJs, and the Medicare Appeals Council to follow all laws and regulations pertaining to the Medicare and Medicaid programs, as well as CMS Rulings and National Coverage Determinations. These adjudicators are also required to give substantial deference to other CMS and Medicare Administrative Contractor guidance, including Medicare manuals and Local Coverage Determinations.

CMS establishes the policies governing Medicare. In 2010, OMHA began a program of coordinated training using policy experts from CMS and the Medicare Appeals Council to provide training to adjudicators throughout the year on Medicare policy. OMHA has enhanced its quality assurance program, and introduced a tool for ALJs and their staff to access and search Level IV Medicare Appeals Council decisions. OMHA also continues to provide ALJ and their staff with regular updates on relevant CMS rulemaking and changes to Medicare manuals. As described in the FY 2016 President's Budget, CMS is pursuing more resources for contractors to participate in ALJ hearings to help ensure that ALJs have all of the information necessary to make a decision, not just the views of the appealing party. Together, these measures will help ensure ALJs have the necessary training and information to make informed decisions, and that adjudicators follow binding authority and give appropriate deference to guidance materials.

Although the potential for a more favorable result is certainly a factor that prompts parties to appeal, thus, increasing the appeal rates, there are other factors which may have a more significant impact on appeal rates. Low jurisdictional thresholds in terms of the monetary amount in controversy required to appeal to OMHA combined with the lack of a filing fee to appeal, provide no incentives for providers and suppliers to evaluate the merits of their claims prior to filing which could encourage them to continually appeal. The Department has proposed in the FY 2016 President's Budget legislative measures to address these drivers by establishing a refundable filing fee at each level and increasing the monetary amount that must be at issue in order to appeal to the Office of Medicare Hearings and Ap-

[5] The Recovery Auditor demonstration project was required by section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the Congress expanded the program in section 302 of the Tax Relief and Health Care Act of 2006, directing CMS to implement a permanent national recovery audit contractor program by January 1, 2010.

peals. These measures will provide incentives which will encourage appellants to evaluate their claims prior to filing and to only appeal meritorious claims.

Question. How will the proposals in the President's Budget, such as case consolidation and a refundable filing fee for providers who prevail on appeal, reduce the backlog of cases resulting from providers' decisions to appeal Medicare contractors' decisions?

Answer. The Department has a three-pronged approach to addressing the increasing number of Medicare appeals and the current backlog: First, invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog, as described in the FY 2016 President's budget. Second, take administrative actions to reduce the backlog and to appropriately resolve claims at earlier levels of the appeals process. Third, pursue legislative proposals described in the President's FY 2016 Budget that provide additional funding and new authorities to address this urgent need.

Legislative proposals along with additional resources requested in the President's FY 2016 Budget set a framework for bringing the Medicare appeals process into balance going forward. For example, the legislative proposal to establish a refundable filing fee at each level of appeal will encourage providers to be more judicious in determining what they appeal. Providing authority to consolidate appeals requests, or group similar claims together to allow for a single decision on multiple claims, will improve the efficiency and timeliness of the Medicare appeals process. Increasing the minimum amount in controversy required for adjudication by an ALJ to the Federal District Court amount in controversy requirement will reduce the volume of claims that could be appealed for ALJ review.

The Budget requests $270 million, an increase of $183 million above the FY 2015 level, to address the backlog of over 800,000 pending appeals at OMHA. The Budget includes $140 million in budget authority and $130 million in program level funding from proposed legislation to support new field offices and additional Administrative Law Judges teams. It will also support appeals adjudication by less costly methods such as settlement facilitation and the proposed Medicare Magistrate program. The 2016 Budget invests $36.2 million to allow CMS to engage in discussions with providers to resolve disputes earlier in the appeals process and greater CMS participation in Administrative Law Judge hearings at OMHA. This investment will improve the efficiency of the Medicare appeals process at the third and fourth levels and reduce the number of claims appealed beyond the CMS levels, enabling the OMHA to more quickly adjudicate its current backlog. The Budget also requests $12.5 million, an increase of $2.5 million above FY 2015 level, to hire additional staff to address Medicare appeals at Level IV (the Medicare Appeals Council).

Question. Administrative Law Judges have been overruling determinations made at the lower levels of appeal as a result of not being familiar with Medicare policy. This budget calls for funding OMHA with recoveries from the Recovery Audit Contractor program.

What assurances do we have that these dollars will be used to educate ALJs on the proper interpretation of Medicare policy?

Answer. The President's Budget includes increased resources from general budget authority, and program authority including recovery audit recoveries, and filing fees for OMHA to address the backlog of appeals, and the appeal receipts going forward. In order to address the workload, improve the overall appeals process, and increase stakeholder confidence in decision making, OMHA recognizes the importance of investing in education for ALJs and their staff. Even with limited resources in the face of significantly growing workloads, OMHA has made education a priority, working with CMS and the Medicare Appeals Council on coordinated training, establishing an internal cadre of seasoned ALJs and attorney advisors to educate new staff, and providing continuing education for existing staff. At the FY 2016 requested funding level, OMHA would continue its commitment to providing thorough training and continuing education for ALJs and support staff. However, the Department notes that OMHA ALJ decisions that overturn CMS contractor denials result from many factors, including new evidence being presented for good cause, the appellant having an opportunity to discuss the evidence and explain what transpired in the clinical setting, and the authority to decline to apply Medicare manuals and contractor policies when warranted by the circumstances (an authority shared with the QICs and the Medicare Appeals Council). Since 2012 the rates at which OMHA adjudicators reverse lower level decisions has declined significantly, indicating that

coordinated training efforts have resulted in increased consistency in decision making throughout the process.

PRECISION MEDICINE INITIATIVE

Question. The Administration recently announced its Precision Medicine Initiative for the purpose of investing in a new generation of lifesaving discoveries based on the recent advances in genetic research. One of its goals is to assemble a database of one million volunteers. The Utah Population Database (UPDB) today represents over 7.3 million people connected to 23 million records, including vital statistics and medical records. It is the world's largest repository of genealogies, public health and medical records—and it is already a powerful resource for advancing precision medicine. Using the UPDB, researchers at the Utah Genome Project (UGP) have so far identified genes that contribute to more than 30 diseases, including breast cancer, heart disease, melanoma, and colon cancer, opening the doors to new personalized diagnostics and therapies. The UGP is housed at the University of Utah Health Sciences and Huntsman Cancer Institute. The UPDB is not only ahead of the curve, but also is a unique resource that is unlikely to be duplicated. The deep family histories represented within UPDB are made possible by a cultural emphasis within Utah on large families and carefully assembled extensive genealogies, the combination of which serve as a magnifying glass to uncover inherited genetic mutations that cause specific diseases. Moreover, many of the methods and tools used to discover these genes, and to understand their function, were developed by scientists at the University of Utah. The UGP is now focusing on UPDB families with exceptionally high incidences of diseases such as type 2 diabetes, multiple sclerosis, and early-onset heart disease. Multigenerational families have already been identified in which dozens of relatives are affected with the same disease, often at an unusually early age. The UGP offers a fresh angle and a powerful approach for disease-gene identification.

Do you agree with me that the UGP is a resource that should fit well within the goals of the Administration's Precision Medicine Initiative?

Answer. I appreciate your interest in the President's Precision Medicine Initiative (PMI). The National Institutes of Health (NIH) assembled a PMI Working Group of the Advisory Committee to the NIH Director (ACD) charged with delivering a report to the ACD in September that articulates the vision for building a research cohort of one million or more voluntary participants. To help inform the report, the PMI ACD Working Group will gather additional input from a wide variety of stakeholders through a series of public workshops over the next several months on topics around precision medicine. One of these workshops, which will be held at the end of May, will focus on recommending the optimal strategy for designing and assembling the national research PMI cohort. The output of that workshop and the ACD Working Group process will better inform NIH and the Administration about the ideal clinical research entities to potentially include in the cohort. The NIH hopes that stakeholders associated with a wide variety of national resources like UGP will be part of this dialogue. The resulting ACD report recommendations will, if accepted by the NIH Director, significantly inform what kind of resources are appropriate to include in the cohort in the near and longer term.

CHILD SUPPORT ENFORCEMENT

Question. Secretary Burwell, on November 17, 2014, HHS published a Notice of Proposed Rule Making (NPRM) in the Federal Register. This NPRM, the "Flexibility, Efficiency and Modernization in Child Support Enforcement Programs," if implemented would result in numerous significant changes to Child Support Enforcement Programs. On December 22, 2014, former House Ways and Means Committee Chairman Dave Camp and I wrote to you expressing our belief that the NPRM exceeds the Department's authority to interpret Congressional intent and implement current law. As this Administration has done on a number of occasions, I believe this Administration is attempting to bypass the Congress in order to enact legislative policies without appropriate action from the legislative branch.

I, along with current Ways and Means Committee Chairman Paul Ryan, are contemplating how best to address this current example of executive over-reach. As we undertake this exercise, we would like to proceed in as thoughtful a way as possible. For example, while we believe there are aspects of the NPRM which clearly extend beyond the authority of the Department, other elements appear to be within your proper regulatory authority or at least are open to that interpretation.

In order to inform our review of these proposals, I request a detailed assessment of the Department's legal justification for the following sections which include changes to current law contemplated by the NPRM:

Section 302.38, which includes a new prohibition precluding a State IV–D program from disbursing child support collections to private collection agencies;

Section 302.56, which creates a new requirement setting parameters relative to the percent of the obligor's income which the state can require as part of a child support payment;

Section 302.56, which sets a new criterion to prohibit the treatment of incarceration as "voluntary unemployment";

Section 302.56, which creates a new Federal Financial Participation (FFP) for parenting time;

Section 302.76, which creates an entirely new job services program for which states are eligible for FFP;

Section 303.8, which is a new provision allowing Medicaid and CHIP to be considered medical support;

Section 303.8, which is a new criterion preventing regular Social Security payments from being garnished under an existing child support order; and

Section 304.20, which details new expenditures subject to FFP. I would encourage you to provide the Committee with as robust and comprehensive ananalysis as possible.

Answer. Thank you for the opportunity for a dialogue on these important issues. We would be pleased to collaborate with you on legislation regarding them, if you wish.

Section 302.38, which includes a new prohibition precluding a State IV–D program from disbursing child support collections to private collection agencies.

This provision implements sections 457(a)(4) and 454(11)(B) of the Social Security Act (Act), pertaining to distribution of the child support collections. Section 457(a)(4) provides that, with respect to families that never received assistance, "the State *shall distribute to the family* the portion of the amount so collected" after deducting the state fee required by statute. This statutory provision requires child support collections to be distributed to the family served by the state child support agency when the family has not received public assistance from the state. Section 454(11)(B) of the Act provides that "any payment required to be made under section 656 or 657 of this title [sections 456 and 457 of the Act] to a family *shall be made to the resident parent, legal guardian, or caretaker relative having custody of or responsibility for the child or children.*" The proposed rule carries out the Congressional intent that moneys collected be paid to families. In addition, the Department has authority under section 452(a)(1) of the Act to "establish such standards for State programs for locating noncustodial parents, establishing paternity, and obtaining child support . . . as he determines to be necessary to assure that such programs will be effective." Section 454(13) provides that "the State will comply with such other requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating noncustodial parents, establishing paternity, obtaining support orders, and collecting support payments and provide that information requests by parents who are residents of other States be treated with the same priority as requests by parents who are residents of the State submitting the plan."

The primary goal of the Child Support Enforcement program is to ensure that families benefit directly from child support payments. Accordingly, states must provide in their state child support enforcement plans that any payments required to be made to a family pursuant to section 457 must be made to "the resident parent, legal guardian, or caretaker relative having custody of or responsibility for the child or children." This provision overlaps with and is reinforced by section 453(c)(3) authorizing the same categories of individuals to receive child support information. Each of these individuals has a relationship with the child that imposes responsibility to protect and further the child's best interests, while private collection agencies historically do not. Based on information available in the past two decades about the practices of private collections agencies, detailed below, the Department has determined that the practices undermine the intent of Congress, clearly stated in the statute, that payments collected by the state for families are to be paid to the family and not to third party creditors.

The proposed rule does not in any way regulate the relationship between custodial parents and private collection agencies or prevent custodial parents from entering into contracts with private collection agencies. Instead, the intent of the proposed rule is to regulate state distribution of funds to families in accordance with section 457(a)(4) and 454(11)(B). The proposed rule would take state child support agencies out of the business of indirectly enforcing private contracts between parents and private collection agencies that purport to require the state agency to divert child support payments to a particular creditor of the custodial parent, or any creditor of the custodial parent, as such distribution is not supported by title IV–D. In addition, evidence from a number of family distribution studies indicates that the child support program is most effective in obtaining child support when collections are paid directly to the family. This rule is intended to clarify policy regarding payment disbursement to families, strengthen parents' commitment to supporting their children, and ensure families' self-sufficiency. We believe the rule will improve child support payment compliance and program effectiveness.

Private collection agencies enter into contracts with custodial parents to collect child support, often times using deceptive and abusive practices. Under the terms of such contracts, when a payment of child support is paid to the state child support agency, the custodial parent owes the private collection agency the contractual fee, regardless of whether the private collection agency's efforts resulted in the payment. State court decisions, consumer complaints, and extensive national media coverage over the past two decades establish that some state child support agencies were pressured to distribute support payments collected through state efforts to private collection companies, rather than families as required by section s 454(11)(B) and 457(a)(4). The court decisions and consumer complaints concerned a common practice by private collection agencies of withholding between 29 and 35 percent before disbursing the collections collected by the state to custodial parents. Such companies deceptively claimed credit for the successful state collection efforts.

A typical example involves a custodial parent learning that after entering into a contract with a company that she received even less child support than before, since amounts previously distributed to her by the state were now one-third lower. When she would confront the company and attempt to cancel the contract, the company typically would tell the custodial parent that she could not get out of the contract until the entire amount of child support debt had been paid off and then threaten a lawsuit against her. Such companies also engage in other deceptive and abusive practices such as posing as a government agency, fraudulently inflating the amount of child support debt to create a "contract for life," refusing to provide an account to parents of child support payments and fees retained by the companies, and demanding immediate payments from grandparents and threatening to send the noncustodial parent to jail if payments are not made. Consumer complaints also indicate that some private collection companies refuse to release the custodial parents from the contract even when the custodial parents complain of increased strain placed on family relationships due to the companies' abusive practices, including harm to the noncustodial parent's relationship with their child, or an elevated fear of domestic violence by the noncustodial parent. We would be happy to further brief your staff on the practices of these types of private agencies and the need to update the regulations in this area.

Section 302.56, which creates a new requirement setting parameters relative to the percent of the obligor's income which the state can require as part of a child support payment.

The Child Support Enforcement Amendments of 1984 (Pub. L. 98–378) added section 467 to require each state, as a condition of state IV–D plan approval, to establish guidelines to establish appropriate child support award amounts within the State. The Family Support Act of 1988 amended section 467 to require that the State's guidelines be used to create a rebuttable presumption that the amount of the child support order is the "correct" amount based on numeric income-based guidelines. The statute further provides that a written finding or specific finding on the record that application of the guidelines would be unjust or inappropriate in a particular case, as determined under criteria established by the state, shall be sufficient to rebut the presumption in that case. The state is required to review the guidelines at least every four years to ensure that their application results in the determination of appropriate child support award amounts. The Department has authority under section 452(a)(1) of the Social Security Act to "establish such standards for locating noncustodial parents, establishing paternity, and obtaining child support . . . as he determines to be necessary to assure that such programs will be effective." Section 454(13) provides that "the State will comply with such other

requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating noncustodial parents, establishing paternity, obtaining support orders, and collecting support payments and provide that information requests by parents who are residents of other States be treated with the same priority as requests by parents who are residents of the State submitting the plan."

Pursuant to sections 467, 454(13), and 452(a)(1), the Department promulgated 45 C.F.R. 302.56 in 1985. The guidelines regulations have been revised two times since 1985. The Department proposes to amend its existing rule to provide that state guidelines take into consideration the noncustodial parent's actual income and subsistence needs (as defined by the state in its guidelines) and provide that amounts ordered for support be based upon available data related to the parent's actual earnings, income, assets, or other evidence of ability to pay, such as testimony that income or assets are not consistent with a noncustodial parent's current standard of living.

One approach that a number of states have implemented to consider the subsistence needs of the noncustodial parents is to incorporate a self-support reserve into their guidelines to recognize the noncustodial parents' subsistence needs, that is, the minimum food, shelter and other basic needs necessary to support life.[6] For example, New Jersey defines a self-support reserve as the amount of income that the state determines is necessary to ensure that a noncustodial parent "has sufficient income to maintain a basic subsistence level and the incentive to work so that child support can be paid." This reserve amount can be either disregarded or used to adjust the child support obligation so the noncustodial parent is able to meet his basic needs.[7]

The basic premise of state guidelines is to establish policies that result in an accurate child support order based upon evidence of the parent's ability to pay, considering the specific circumstances of the parties and the best interests of the child. The proposed regulation in δ302.56(c)(4) gives states wide latitude to develop guidelines for fair orders resulting in reliable child support payments to families. For example, the proposed rule permits a state to impute income where the noncustodial parent's lifestyle is inconsistent with claimed earnings or income. In setting an order, a court may also take the earning capacity of the parents into account. An example of this would be a noncustodial parent who, despite good educational credentials and marketable job skills, simply refuses to work. In this situation the court may deviate from the guidelines to impute income based on earning capacity.

However, the evidence is clear that child support is not paid when the child support order is set beyond the means of a noncustodial parent to comply with the order. A growing body of research finds that compliance with child support orders in some states, regardless of income level, declines when the support obligation is set above 15 to 20 percent of the obligor's gross wages or income, and that orders for excessive amounts result in lower, not higher, child support payments.[8] The HHS Office of Inspector General concluded that child support orders set for low income parents are ineffective in generating child support payments when set too high relative to ability to pay, finding that compliance is significantly lower when a monthly order is more than 20 percent of a parent's income than when it is 15 percent or less.[9] Setting child support orders that reflect ability to pay is crucial to encouraging compliance, increasing parental accountability for making payments, and discouraging uncollectible arrearages.

Research also suggests that noncustodial parents are less likely to pay their support orders when they are based on presumed income, such as 40 hour minimum wage employment, or set at a standard level (such as the cash assistance amount

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[6] Carmen Solomon-Fears. *Fatherhood Initiatives: Connecting Fathers to Their Children.* Congressional Research Service(2015), available at: *http://fas.org/sgp/crs/misc/RL31025.pdf.*

[7] Rules Governing the Courts of New Jersey, Appendix IX–A Considerations in the Use of Child Support Guidelines, Section 7.h., Self-Support Reserve, available at: *http://www.judiciary.state.nj.us/csguide/app9a.pdf.*

[8] Mark Takayesu, *How Do Child Support Order Amounts Affect Payments and Compliance?* Orange County, CA Department of Child Support Services (2011), available at: *http://ncsea.omnibooksonline.com/2012policyforum/data/papers/PV_1.pdf#page=1;* Carl Formoso, *Determining the Composition and Collectability of Child Support Arrearages, Volume 1: The Longitudinal Analysis* (2003), available at:*https://www.dshs.wa.gov/pdf/esa/dcs/reports/cvol1prn.pdf.*

[9] HHS Office of Inspector General (OIG), *The Establishment of Child Support Orders for Low Income Non-custodial Parents,* OEI–05–99–00390 (2000), available at:
http://oig.hhs.gov/oei/reports/oei-05-99-00390.pdf.

received by the custodial family) that is often well above the parent's ability to pay.[10] Such imputed income orders are not based on evidence of actual income and result in high uncollectible arrears balances that can provide a disincentive for obligors to maintain employment in the regular economy. Uncollectible debt does not accomplish the goals of the child support program to obtain child support. Most arrearages are owed by noncustodial parents with earnings under $10,000 and are uncollectible.[11] Research finds that high arrearages substantially reduce the formal earnings of noncustodial parents and child support payments in economically disadvantaged families, while reducing unmanageable arrearages can increase payments.[12] Accumulation of high arrearage balances is often associated with incarceration because parents have little to no ability to earn income while they are incarcerated, and little ability to pay off the arrearages when released due to lack of employment.

Our proposed regulations are intended to ensure that state guidelines result in appropriate support orders based upon available evidence of an individual parent's ability to pay and to correct the ineffective practice in some states of setting orders in low-income cases that are not based upon any evidence of the parents' specific circumstances but instead simply assume full-time employment. Parents cannot comply with orders set above their means to pay what is ordered. Several studies make clear that when orders are set above the noncustodial parent's ability to pay, compliance drops—they pay less money than if the orders were set based on the parent's ability to pay. The research is clear that when orders are set too high, low-income parents are far less likely to stay employed in low-wage jobs and pay child support. They are more likely to avoid contact with the child support program and their children. They are more likely to enter the underground economy and, often, prison, a result that is not good for children. Regular employment and consistent child support payments collected every month through income withholding is what helps custodial families achieve economic stability. Sustainable payments paid on time every month is especially important to the millions of low- and moderate-income families served by the child support program. When families receive regular child support payment, they are less likely to need public assistance.[13] We believe that this provision will improve child support payment compliance and program effectiveness.

Section 302.56, which sets a new criterion to prohibit the treatment of incarceration as "voluntary unemployment."

Section 467 of the Social Security Act requires states to establish guidelines for setting appropriate support orders. Section 454(4) requires states to provide services relating to order establishment and modification to any child receiving services under title IV–D. Section 454(20) requires states to have in effect laws to improve child support effectiveness listed in section 466 of the Act, including section 466(a)(10), which requires states to have procedures under which every 3 years, upon the request of either parent (or the state, if there is an assignment under part A of the Social Security Act), the state must review and, if appropriate, adjust the order in accordance with the guidelines established pursuant to section 467(a), taking into account the best interests of the child.

The Department has authority under section 452(a)(1) of the Social Security Act to "establish such standards for locating noncustodial parents, establishing paternity, and obtaining child support . . . as he determines to be necessary to assure that such programs will be effective." Section 454(13) provides that "the State will comply with such other requirements and standards as the Secretary determines to

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[10] Letitia Logan Passarella and Catherine E. Born, *Imputed Income Among Noncustodial Parents: Characteristics and Payment Outcomes.* University of Maryland, School of Social Work (2014), available at: *http://www.familywelfare.umaryland.edu/reports1/imputed.pdf.*

[11] Elaine Sorensen, Liliana Sousa, and Simon Schaner, *Assessing Child Support Arrears in Nine Large States and the Nation,* The Urban Institute (2007), available at: *http://aspe.hhs.gov/hsp/07/assessing-CS-debt/.*

[12] Carmen Solomon-Fears, Gene Falk, and Adrienne L. Fernandes-Alcantara, *Child Well-Being and Noncustodial Fathers,* Congressional Research Service (2013), available at: *http://fas.org/sgp/crs/misc/R41431.pdf;* Carolyn J. Heinrich, Brett C. Burkhardt, and Hilary M. Shager, *Reducing Child Support Debt and Its Consequences: Can Forgiveness Benefit All?* Institute for Research on Poverty (2010), available at:
http://www.irp.wisc.edu/research/childsup/cspolicy/pdfs/2007-09/FamiliesForward_3_19_10.pdf.

[13] Carl Formoso, *Child Support Enforcement: Net Impacts on Work and Welfare Outcomes pre- & post-PRWORA,* Washington State Division of Child Support (2000), available at: *http://www.dshs.wa.gov/pdf/esa/dcs/reports/csepolicybrief.pdf.*

be necessary to the establishment of an effective program for locating noncustodial parents, establishing paternity, obtaining support orders, and collecting support payments and provide that information requests by parents who are residents of other States be treated with the same priority as requests by parents who are residents of the State submitting the plan."

Pursuant to sections 467, 454(13), and 452(a)(1), the Department promulgated 45 C.F.R. 302.56 in 1985. The guidelines regulations have been revised in 1991 and 2008. The existing rule, 45 C.F.R. 302.56, requires states to set numeric guidelines that take earnings and income into consideration and to review and revise the guidelines every 4 years to ensure appropriate and correct child support order amounts. Existing rule, 45 C.F.R. 303.8(b)(3)(ii)(A) requires both upward and downward changes in the amount of the support order. Existing rule 45 C.F.R. 303.8(b)(5) also requires the state to have procedures to review orders outside of the 3-year cycle if the requesting party demonstrates a "substantial change in circumstances." Existing rule 45 C.F.R. 303.8(b)(6) requires states to provide notice not less than once every 3 years to the parents subject to the order informing them of their right to request a review and adjustment.

In order to carry out statutory requirements that state guidelines produce appropriate orders, and that states review and adjust orders upon a substantial change in circumstances, and our statutory responsibility to improve program effectiveness, the proposed rule would amend 45 C.F.R. 302.56 to provide that state guidelines may not treat incarceration as "voluntary unemployment" in establishing or modifying child support orders. The effect of the proposed rule is to require states to carry out the review and adjustment requirements of section 466(a)(10), prohibiting states from legally precluding review and, if appropriate, adjustment of support orders during incarceration. If an incarcerated noncustodial parent has income or assets, the proposed rule permits orders to be set taking that income or those assets into account.

Voluntary unemployment policies are yet another form of income imputation that results in inappropriate support orders, prevents review and adjustment of such support orders as required by federal statute, and is contrary to the evidence of what works to increase child support payments. The consequence of voluntary unemployment policies is to maintain pre-incarceration support order amounts that are not based on the earnings and income available to incarcerated parents, resulting in the accumulation of an additional $23,000 on average of uncollectible debt during incarceration.[14] The research indicates that accumulation of uncollectible debt results in a number of harmful outcomes, including decreased employment, increased participation in the underground economy, increased crime and recidivism, and increased father absence.[15] All of these outcomes reduce child support collections and hurt children.

Over the last 15 years, most states have eliminated the "voluntary unemployment" provision in their guidelines that precludes review and adjustment of the orders of incarcerated parents. At least 36 states, including Wisconsin and Utah, currently permit review and adjustment during incarceration of the noncustodial parent, while 14 do not. A number of state supreme courts have rejected the approach that a parent's reduction in income due to incarceration is "voluntary unemployment" or that order amounts should remain at pre-incarceration levels. Instead,

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[14] Nancy Thoennes, *Child Support Profile: Massachusetts Incarcerated and Paroled Parents,* Center for Policy Research (2002), available at:*http://cntrpolres.qwestoffice.net/reports/profile%20of%20CS%20among%20incarcerated%20&%20paroled%20parents.pdf.*

[15] Carmen Solomon-Fears, Gene Falk, and Adrienne L. Fernandes-Alcantara. *Child Well-Being and Noncustodial Fathers,* Congressional Research Service (2013), available at: *http://fas.org/sgp/crs/misc/R41431.pdf;* Harry Holzer, Paul Offner, and Elaine Sorensen. *Declining Employment Among Young Black Less-Educated Men: The Role of Incarceration and Child Support* (2004), available at:

http://www.urban.org/UploadedPDF/411035_declining_employment.pdf; Judi Bartfeld and Dan Meyer. *Child Support Compliance Among Discretionary and Nondiscretionary Obligors,* 77 Soc. Serv. Rev. 347 (2003), available at:

http://www.jstor.org/discover/10.1086/375793?sid=21106384595223&uid=3739936&uid=2&uid=4&uid=3739256; Elaine Sorensen, Liliana Sousa, and Simone Schaner. *Assessing Child Support Arrears in Nine Large States and the Nation,* The Urban Institute (2007); HHS, Office of Inspector General, *The Establishment of Child Support Orders for Low Income Non-custodial Parents,* 2000, OEI–05–99–00390, available at *https://oig.hhs.gov/oei/reports/oei-05-99-00390.pdf.*

these courts have found that orders based on the actual income and assets available to the parent are most likely to produce support payments upon release.[16]

In a 2005 bipartisan report based upon the work of state judges, attorneys general, corrections officers, law enforcement officials, victims representatives, and community-based programs, the Council of State Governments identified child support obligations, especially arrearages, as a barrier to successful re-entry into society because they have a tendency to disrupt family reunification, parent-child contact, and the employment patterns of ex-prisoners, and recommended against voluntary unemployment child support policies.[17] State child support programs have found that they can make their programs more successful by identifying parents with support obligations while they are in prison so that parents are better able to avoid the accumulation of excessive child support debt by requesting an order modification to reflect their current ability to pay.[18]

Section 302.56, recognizes existing state child support order establishment practices and clarifies the extent of state flexibility to incorporate Parenting Time into child support orders.

Section 467 of the Social Security Act requires states to establish guidelines for setting child support award amounts within the state. The State must review their guidelines every 4 years to ensure that the application of the guidelines results in the determination of appropriate child support award amounts.

The Department has authority under section 452(a)(1) of the Act to "establish such standards for locating noncustodial parents, establishing paternity, and obtaining child support . . . as he determines to be necessary to assure that such programs will be effective." Also, section 454(13) provides that "the State will comply with such other requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating noncustodial parents, establishing paternity, obtaining support orders, and collecting support payments and provide that information requests by parents who are residents of other States be treated with the same priority as request by parents who are residents of the State submitting the plan."

In 1985, the Department promulgated 45 C.F.R. 302.56 to implement section 467 and 452(a)(1) of the Act. The rule has been revised two times since 1985. Specifically, the existing rule requires states to set numeric guidelines that take all earnings and income of the noncustodial parent into consideration, be based on specific descriptive and numeric criteria and result in a computation of the support obligation, and address how the parents will provide for the children's health care needs. Additionally, the state must review and revise, if appropriate, the guidelines every 4 years to ensure appropriate child support order amounts.

The Department proposes to amend its existing rule to recognize legal developments in states over the past two decades and current state IV–D program activities that do not result in identifiable costs to the federal government. We believe that this provision will reflect the current practice in some States, recognize judicial flexibility in others, and improve child support payment compliance and program effectiveness. FFP is available to states to establish child support orders. The provision is intended only to clarify that states do not need to develop complicated cost allocation formulas to somehow separate out the incidental costs associated with applying the parenting time aspect of child support guidelines to determine child support order amounts, or require parents to return to court another day if they wish to submit to the judge a parenting time agreement that they have worked out ahead of time so that it can be included in the child support order.

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[16] See e.g., *Lambert v. Lambert,* 861 N.E.2d 1176, 1180 (Ind. 2007), (stating "the conclusion is also supported by the overarching policy goal of all family court matters involving children: protecting the best interests of those children."),
http://www.ai.org/judiciary/opinions/pdf/02220701rts.pdf; State v. Porter, 610 N.W.2d 23 (Neb. 2000) (holding that initial child support determination which was based upon the father's earning capacity prior to his incarceration constituted abuse of discretion noting that during the parent's incarceration, the judgment would simply accrue with interest and not benefit the child.)

[17] *Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community,http://csgjusticecenter.org/reentry/publications/the-report-of-the-re-entry-policy-council-charting-the-safe-and-successful-return-of-prisoners-to-the-community/* (Policy Statement 13, pp. 198–2000).

[18] Carmen Solomon-Fears, Gene Falk, and Adrienne L. Fernandes-Alcantara. *Child Well-Being and Noncustodial Fathers,* Congressional Research Service (2013), available at:
http://fas.org/sgp/crs/misc/R41431.pdf.

A number of state legislatures, such as New Jersey, Texas, Tennessee, and Oregon, have incorporated parenting time factors into their state guidelines calculations and established shared parenting presumptions to recognize the trend toward shared parenting. Although parenting time is a legally distinct and separate right from the child support obligation, the research finds that parents are more willing to pay child support if they are able to play an active parenting role.[19] Thus, states have concluded that the recognition of parenting time can improve child support compliance and program effectiveness.[20] States have been further encouraged to coordinate child support and parenting time by the Sense of Congress provision included in the *Preventing Sex Trafficking and Strengthening Families Act of 2014,* § 303, Pub. L. 113–183. Some state courts judges and administrators have encouraged the Department to clarify existing authority to recognize state guidelines provisions and inclusion of parenting time agreements in a child support orders.

The Department's proposed rule reflects the trend of states to incorporate parenting time into their guidelines. The proposed rule acknowledges these developments[21] by adding a new criterion as δ 302.56(h) to clarify that states may recognize parenting time agreements included in child support orders. "State child support guidelines that incorporate parenting time" refers to those States that have guidelines which incorporate allowances (or credits) for the amount of time children spend with both parents in the calculation of the child support order amount.

The proposed parenting time provision is a minor change to existing regulations intended to clarify that a court or child support agency may include an uncontested parenting time agreement into the child support order at the time the child support order is entered without violating federal child support regulations. The proposed rule would remove uncertainty about whether a parenting time agreement may be included in a child support order when IV–D program attorneys are present at the hearing. Allowing a court to address both child support and a parenting time agreement in one hearing, when the parents are present and willing, increases efficiency and reduces the burden on parents of participating in multiple administrative or judicial processes without increasing IV–D program costs.[22] Child well-being is positively affected when the noncustodial parents become more responsible and involved with their children.[23]

The intent of the rule is to modestly increase state flexibility, not to increase federal expenditures. This new parenting time provision does not permit state IV–D agencies to claim Federal Financial Participation for a parenting time program or activities using IV–D program funds and has no additional impact on the federal budget. If a state incurs costs for parenting time activities, such as mediation or legal assistance, it must do so with other funds. Under the proposed rule, IV–D program costs must be minimal and incidental to IV–D establishment activities. Our proposed regulation is intended to clarify that a state does not need to establish a cost allocation plan or require parents to come back for a second court hearing if they ask the judge to include an uncontested and agreed upon parenting time provision incidental to the establishment of a child support order when convenient to the parties, IV–D agency and court to do so.

The NPRM proposes minimal clarifying changes to increase state flexibility, recognize existing state practice, and avoid the creation of cost allocation formulas to address trivial costs. It does not require or permit state IV–D agencies to undertake new functions that do not carry out the child support purposes defined in statute. However, the President's Budget Proposal calls for new legislation that would expand the statutory responsibilities of the child support program to include parenting time establishment. Specifically, "federal resources are made available to states that choose to include parenting time responsibilities in initial child support orders beginning in FY 2016 and all states are required to include parenting time responsibilities in all new child support orders beginning in FY 2021."

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[19] Kathryn Edin and Timothy Nelson. *Doing the Best I Can: Fatherhood in the Inner City,* University of California Press (2013).

[20] National Child Support Enforcement Association, *Parenting Time Orders.* July 21, 2013, available at: *http://www.ncsea.org/documents/Parenting-Time-Order_7.31.13.pdf.*

[21] Carmen Solomon-Fears, Gene Falk, and Adrienne L. Fernandes-Alcantara. *Child Well-Being and Noncustodial Fathers,* Congressional Research Service (2013), available at: *http://fas.org/sgp/crs/misc/R41431.pdf.*

[22] Alicia Key, *Parenting Time in Child Support Cases in Texas,* Family Court Review (Forthcoming 2015).

[23] Carmen Solomon-Fears, Gene Falk, and Adrienne L. Fernandes-Alcantara. *Child Well-Being and Noncustodial Fathers,* Congressional Research Service (2013), available at: *http://fas.org/sgp/crs/misc/R41431.pdf.*

Section 302.76, which provides states additional flexibility to adopt evidence-based practices to improve program effectiveness and recognizes that parents cannot pay regular child support unless they have a job.

Section 452(a)(1) of the Social Security Act provides the Secretary with authority to "establish such standards for State programs for locating noncustodial parents, establishing paternity, and obtaining child support . . . as he determines to be necessary to assure that such programs will be effective." Section 454(13) requires the state plan to "provide that the State will comply with such other requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating noncustodial parents, establishing paternity, obtaining support orders, and collecting support payments. . . ." The proposed rule is informed by section 466(a)(15), which requires states to have procedures to request a court or administrative agency to order an individual to participate in a plan for noncustodial parents with overdue TANF arrears to pay or participate in work activities.

With very few exceptions, the federal government reimburses the cost of procedures implemented by states under section 466, including paternity acknowledgments, tax refund offsets, enforcement of liens, review and modification of support orders, drivers' license suspension, and income withholding activities. While the other procedures in section 466 are effective in cases where the noncustodial parent has income or resources, they are not effective in situations where the noncustodial parent lacks a job.

The most effective procedure in section 466 is income withholding, which accounts for 75 percent of all IV–D child support collections. In addition, income withholding results in regular child support payments made on time every month. However, income withholding is only effective when a noncustodial parent has wages or other monthly income. The evidence is clear that the main reason for non-payment of child support is unemployment.[24]

Based on information from recent studies about child support-led employment programs, the Department has determined that authorizing FFP for such programs is a reasonable and cost-effective method for obtaining and increasing collection of child support payments and improved program performance. In fact, noncustodial parent employment services can be a more productive and cost-effective tool for increasing collections in hard-to-collect cases than the traditional enforcement tools reimbursed under current rules. If the proposed rule is adopted, we expect that some states would redirect funding toward more effective approaches and away from less productive efforts. This is particularly so because states put up a 34 percent match and state incentive funding is based upon performance improvements. The proposed work activities are an evidence-based and cost-effective approach to obtaining and increasing child support collections in difficult-to-enforce cases, and would be targeted to non-custodial parents who would likely not otherwise receive employment services. This option provides states with an alternative to repeated, costly, and largely ineffective court hearings and jail time when the reason for non-payment is unemployment.[25]

Studies of state child support-led employment programs for noncustodial parents have shown that these efforts increase employment, earnings, and child support payments.[26] Increased child support payments avoid public assistance costs. When families receive regular child support payments, they use fewer public assistance benefits such as TANF and SNAP.[27] The evidence shows that job services are a more cost-effective way to hold unemployed parents accountable and increase collections than any other approach.[28]

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[24] Carmen Solomon-Fears, Gene Falk, and Adrienne L. Fernandes-Alcantara. *Child Well-Being and Noncustodial Fathers,*Congressional Research Service (2013), available at: *http://fas.org/sgp/crs/misc/R41431.pdf.*

[25] Carmen Solomon-Fears, Gene Falk, and Adrienne L. Fernandes-Alcantara. *Child Well-Being and Noncustodial Fathers,* Congressional Research Service (2013), available at: *http://fas.org/sgp/crs/misc/R41431.pdf.*

[26] Carmen Solomon-Fears. *Fatherhood Initiatives: Connecting Fathers to Their Children.* Congressional Research Service (2015), available at: *http://fas.org/sgp/crs/misc/RL31025.pdf.*

[27] Laura Wheaton. *Child Support Cost Avoidance in 1999,* The Urban Institute (2003), available at: *http://www.acf.hhs.gov/programs/css/resource/child-support-cost-avoidance-in-1999-final-report.*

[28] Daniel Schroeder and Nicholas Doughty, *Texas Non-Custodial Parent Choices: Program Impact Analysis* (2009), available at

Over the past two decades, most state child support agencies have attempted to partner with other programs to establish work slots for noncustodial parents behind in their child support payments. However, despite strong efforts to promote and coordinate work activities for noncustodial parents, few state child support agencies have been able to secure resource commitments for noncustodial parent work activities from TANF and workforce agencies.

Thus, although Congress requires states to have procedures to develop work plans for nonpaying noncustodial parents and require noncustodial parents to participate in work activities, states have had great difficulty carrying out section 466(a)(15). Without funding for jobs activities, child support agencies will continue to spend federal and state resources on court hearings and state resources on jail, but will not accomplish the goal of collecting full and regular child support payments for families. Unless more nonpaying noncustodial parents are able to participate in job activities, more children will go without child support, depend more on public assistance, and remain in poverty.

Section 303.8, which is a new provision allowing Medicaid and CHIP to be considered medical support.

The Child Support Enforcement Amendments of 1984 added section 452(f) of the Act to require the Secretary to issue regulations requiring state child support agencies to petition for the inclusion of a medical support provision in child support orders whenever health care coverage was available to noncustodial parents at a reasonable cost. At the same time, Congress added section 466(a)(19), requiring states to have procedures under which all child support orders include a provision for the health care coverage of the child. As part of the Child Support Performance and Incentive Act of 1998 (CSPIA), Congress established a Medical Child Support Working Group to study medical child support.[29]

In 2006, the Deficit Reduction Act amended section 452(f) to provide that:

> The Secretary shall issue regulations to require that State agencies administering the child support enforcement program under this part enforce medical support included as part of a child support order whenever health care coverage is available to the noncustodial parent at a reasonable cost. A State agency administering the program under this part may enforce medical support against a custodial parent if health coverage is available to the custodial parent at a reasonable cost. Such regulation shall also provide for improved information exchange between such State agencies and the State agencies administering the State Medicaid programs under title XIX with respect to the availability of health insurance coverage. For purposes of this part, the "term "medical support" may include health care coverage, such as coverage under a health insurance plan (including payment of costs of premiums, co-payments, and deductibles) and payment for medical expenses incurred on behalf of a child.

In addition, Congress amended section 466(a)(19)(A) to require states to have procedures under which "all child support orders enforced pursuant to this part shall include a provision for medical support for the child to be provided by either or both parents, and shall be enforced, where appropriate, through the use of the National Medical Support Notice. . . ." Section 454(20) incorporates the procedures in section 466 into the state plan, by requiring states to have in effect laws that implement procedures prescribed in or "pursuant to" section 466 to improve child support enforcement effectiveness.

The Department has additional authority under section 452(a)(1) of the Social Security Act (Act) "to establish such standards for State programs for locating noncustodial parents, establishing paternity, and obtaining child support . . . as he determines to be necessary to assure that such programs will be effective." Section 454(13) provides that "the State will comply with such other requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating noncustodial parents, establishing paternity, obtaining support orders, and collecting support payments and provide that information re-

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https://www.texasattorneygeneral.gov/cs/ofi/ncp_choices_program_impact.pdf; Kye Lippold, Austin Nichols, and ElaineSorensen, *Strengthening Families Through Stronger Fathers: Final Impact Report for the Pilot Employment Programs* (2011), available at:
http://www.urban.org/uploadedpdf/412442-Strengthening-Families-Through-Stronger-Fathers.pdf.

[29] The Medical Child Support Working Group Report, *21 Million Children's Health: Our Shared Responsibility, June 2000,* available at:
http://fatherhood.hhs.gov/medsupport00/chap8.htm.

quests by parents who are residents of other States be treated with the same priority as requests by parents who are residents of the State submitting the plan."

As directed by Congress, the Department promulgated medical support regulations in 1992, 2000, and 2008. In the preamble to its 2000 regulation, we responded to commenters asking whether Medicaid and the State Children's Health Insurance Program should be excluded from consideration as alternative coverage. Our response was that "The statute does not preclude medical support under Medicaid or SCHIP from being stipulated in the order as alternative coverage," but stated that "we are examining the Working Group's recommendations on this issue."[30]

Section 466(a)(19)(a) requires "all child support orders enforced pursuant to this part" to include a provision for medical support for the child to be provided by either or both parents. Employer-sponsored health care coverage is not available to most children in the child support caseload. Although states have committed substantial resources toward increasing the percentage of child support orders that include medical support, federal administrative data indicates that medical support is actually provided as ordered in only 33 percent of cases.[31] The 2009 Center for Policy Research Report analysis of selected states also found that issuing a National Medical Support Notice to the noncustodial parent's employer results in the child being enrolled in a health plan only 10 to 23 percent of the time.[32] An Urban Institute study found that in 2009, only 37 percent of child support-eligible children had parents with employer-sponsored health care.[33] This contrasts with data from two decades earlier included in a 1992 GAO report that "The Bureau of Labor Statistics' 1989 and 1999 surveys of employee benefits indicate that 81 percent of adult workers have insurance available through their employer."[34]

In order to effectively carry out the statutory requirement that states establish medical support orders in all IV–D cases and to improve the effectiveness of the child support program in establishing medical support, the rule proposes to amend the 2008 rule to give states flexibility to recognize the sources of health care coverage—private or public—available to either parent at a reasonable cost. We believe that this provision will improve child support payment compliance and program effectiveness.

Section 303.8, which is a new criterion preventing regular Social Security payments from being garnished under an existing child support order.

Section 459 of the Act provides that only moneys that are based upon remuneration for employment are subject to child support garnishment. Supplemental Security Income (SSI) payments are not based upon remuneration for employment. Rather, they are provided based on need. Since 2000, federal policy on child support garnishments has recognized this exception by directing child support agencies not to collect against SSI benefits (either directly or from bank accounts).[35] Currently, OCSE estimates that about three percent of noncustodial IV–D parents receive SSI.

Additionally, the Department has authority under section 452(a)(1) of the Act to "establish such standards for locating noncustodial parents, establishing paternity, and obtaining child support . . . as he determines to be necessary to assure that such programs will be effective."

Section 454(13) provides that "the State will comply with such other requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating noncustodial parents, establishing paternity, obtaining support orders, and collecting support payments and provide that informa-

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[30] See 65 *Fed. Reg.* 82154, dated December 27, 2000, available at:*http://www.gpo.gov/fdsys/granule/FR-2000-12-27/00-31611.*

[31] Center for Policy Research, *Medical Child Support: State Strategies Re-examined,* prepared under Office of Child Support Enforcement Grant #08–C0067 to the Texas Office of the Attorney General, Division of Child Support (2011).

[32] Center for Policy Research, *Medical Child Support: Strategies Implemented by States,* prepared under Office of Child Support Enforcement Grant #08–C0067 to the Texas Office of the Attorney General, Division of Child Support (2009).

[33] Stacey McMorrow, Genevieve Kenney, Allison Cook, and Christine Coyer. *Health Care Coverage and Medicaid/CHIPEligibility for Child Support Eligible Children.* ASPE Research Brief, available at: *http://aspe.hhs.gov/hsp/11/HealthCare-ChildSupport/rb.shtml.*

[34] General Accounting Office (GAO), *Medicaid: Ensuring That Noncustodial Parents Provide Health Insurance Can Save Costs,* GAO/HRD–92–80, p. 8, June 1992, available at: *http://www.gao.gov/assets/220/216432.pdf.*

[35] See OCSE Dear Colleague Letter (DCL) 00–103, *Attachment of Social Security Benefits,* October 6, 2000, available at:
http://www.acf.hhs.gov/programs/css/resource/attachment-of-social-security-benefits.

tion requests by parents who are residents of other States be treated with the same priority as request by parents who are residents of the State submitting the plan."

The new provisions related to SSI garnishment were added to our proposed rule consistent with Section 459 of the Social Security Act and the rule jointly issued by the Department of Treasury, in conjunction with the Social Security Administration, Department of Veterans Affairs, Office of Personal Management, and the Railroad Retirement Board, on February 23, 2011, to prevent the garnishment of bank accounts containing certain federal benefits.[36] On February 27, 2013, the HHS Office of Child Support Enforcement issued Dear Colleague Letter (DCL) 13–06 providing guidance to state and tribal child support agencies urging them to implement automated and manual safeguards to ensure that Supplemental Security Income (SSI) benefits are not being garnished.[37] The DCL indicated that we were reviewing our regulations to determine if additional requirements were needed to ensure that exempt federal benefits are not garnished.

The Department has been urged by several stakeholders to exclude "dual eligibility" benefits, where the individual is eligible for both SSI and Social Security Disability Insurance (SSDI), meets the income test for SSI benefits, and would have received the same amount in SSI-only funds, but for the fact that the individual qualifies for SSDI benefits as well as SSI benefits. The proposed rule requires states to develop safeguards for the states to prevent garnishment of exempt benefits. These provisions only relate to excluding SSI benefits, as well as concurrent SSI and SSDI benefits.

The proposed rule does not make any revision related to SSDI benefits, which remain subject to garnishment, except in the one circumstance described above. SSDI benefits are considered remuneration from employment, and therefore, state or tribal child support agencies are allowed to continue to garnish the benefits of child support directly from the federal payer as authorized under section 459(h).

The proposed rule requires states to review these noncustodial parents' financial accounts to determine whether there are available assets above subsistence level available for garnishment other than SSI or concurrent SSI and benefits under title II of the Act. The rule also requires states to have automated procedures in place to return funds to a noncustodial parent within 2 days after the agency determines that SSI or concurrent SSI and benefits under title II of the Act in the account have been incorrectly garnished.

The proposed rule is consistent with long-standing federal child support policy and the rule promulgated jointly by Treasury and other federal agencies, and strengthens policies and safeguards to prevent garnishment of low-income noncustodial parents' financial accounts when they are only receiving these exempt benefits, which retain their character as exempt even after being deposited.

Section 304.20, which details new expenditures subject to FFP.

Section 455 of the Social Security Act generally provides that the Secretary will reimburse amounts expended for the operation of the state plan. Section 452(a)(1) of the Social Security Act (Act) provides the Secretary with authority to "establish such standards for State programs for locating noncustodial parents, establishing paternity, and obtaining child support . . . as he determines to be necessary to assure that such programs will be effective." Section 454(13) provides that "the State will comply with such other requirements and standards as the Secretary determines to be necessary to the establishment of an effective program for locating noncustodial parents, establishing paternity, obtaining support orders, and collecting support payments and provide that information requests by parents who are residents of other States be treated with the same priority as requests by parents who are residents of the State submitting the plan."

To implement section 455, the Department promulgated a set of FFP rules, including 45 C.F.R. 304.20, 304.21, 304.23, and 304.26. These rules have been amended 14 times since 1975. Proposed changes to 45 C.F.R. 304.20 would provide clear guidance to states and update existing FFP rules to reflect current practice in the

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[36] See 76 Fed. Reg. 9939, February 23, 2011, available at: *http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=2&ved=0CCYQFjAB&url=http%3A%2F%2Fwww.gpo.gov%2Ffdsys%2Fpkg%2FFR-2011-02-23%2Fpdf%2F2011-3782.pdf&ei=S2MlVdz3J47bsATpsYG4Aw&usg=AFQjCNEYHTclYGyhrjxBJ35wea64XFPtHw.*

[37] See OCSE Dear Colleague Letter (DCL) 13–06, *Garnishment of Supplemental Security Income Benefits,* February 27, 2013,available at:*http://www.acf.hhs.gov/programs/css/resource/garnishment-of-supplemental-security-income-benefits.*

field for the establishment and enforcement of child support orders. The proposed rule articulates standard OMB cost principles incorporated in existing 45 C.F.R. 304.10 to the effect that costs must be necessary, reasonable, and allocable to the child support program.[38]

The proposed rule at 304.20(b)(12) would explicitly permit FFP for educational and outreach activities for the state agency to carry out their responsibilities to publicize child support services under section 454(23) of the Social Security Act and to coordinate with other programs to improve the effectiveness of the child support program. Effective programs incorporate such educational and outreach activities, and this cost is routinely claimed by state child support agencies.

The proposed rule at 304.20(b)(3)(vi) would expressly permit FFP for services to increase *pro se* access to adjudicative and alternative dispute resolution practices. Some states use alternative dispute resolution because it is more effective and less expensive than paying for costly court hearings and attorneys. Alternative dispute resolution also can increase compliance with child support orders more effectively than court hearings because such procedures are less adversarial and damaging to family relationships. Some state courts also provide child support education and assistance to unrepresented parties in child support cases in order to explain the process and help parents complete forms needed in court. The research shows that parents who feel heard and respected by the child support process are more likely to comply with the orders.[39] States using alternative dispute resolution and *pro se* services in child support cases have claimed FFP for these costs for many years.

The proposed rule at 304.20(b)(3)(v) would permit FFP for local bus fare for participants to attend child support appointments and court hearings. Providing FFP for local bus fare can be a cost-effective way to reduce costly no-shows at court, increase parental cooperation, and improve access to legal proceedings. In some states, the no-show rate can be as much as 50 percent. When a parent does not show up, the agency may need to reschedule a paternity genetic test or the court may need to reschedule or reopen an earlier default order—all costs otherwise charged to the federal government.

According to the cost principles, states may only claim such costs if they are necessary, reasonable, and allocable to title IV–D. Under the proposed rule, a state could not claim such costs for custody or child welfare cases, for example, because they would not be allocable to title IV–D.

The proposed rule at 304.20(b)(3)(ix) would provide FFP for certain work activities to increase child support payments through early intervention efforts so as to improve child support outcomes and redirect major program costs associated with repeated and ineffective enforcement efforts, expensive attorney and court time, and jail costs. Legal authority for this provision is discussed in the response to question 5 on Medicaid.

A number of states are moving forward to improve coordination between child support and parenting time. The proposed rule at 304.20(b)(3)(vii) is not intended to expand FFP, but to clarify that FFP is *not* available for parenting time activities. The *de minimis* exception is added to clarify that state allocation plans are not required when the state incurs nominal costs associated with child support guidelines development. Since the late 1990s, several state legislatures have adopted child support guidelines that require the child support agency to calculate parenting time to determine the amount of child support order amounts. In addition, the proposed rule clarifies that parents who have previously worked out a parenting time agreement (without using FFP) do not have to come back for another hearing and state attorneys do not need to leave the courtroom in those situations when a support order is being set and it is convenient for the judge and parents to add the parenting time agreement to the support order. See response to question 4 on Medicaid.

STARK

Question. The Affordable Care Act established procedures for self-reporting Stark law violations. However, hospitals that have followed these procedures to try and reach a settlement for technical noncompliance (ex. administrative mistakes, miss-

[38] See Uniform Guidance for HHS Awards at 45 CFR 75, Subpart E, Cost Principles.

[39] Kelly Macatangay, Anton Westveld, Brian Kunkel, *Intervening for Success.* NV: Clark County District Attorney, Family Support Division (2012); Karen Roye, *Enhanced Parental Involvement Collaborative Project: Final Report.* CA: San Francisco Department of Child Support Services (2006).

ing signatures) are awaiting decisions from CMS for what seems to be an excessive period of time.

How many self-referral disclosures are currently pending a settlement decision by CMS and how many hospitals are involved?

Answer. There are 400 disclosures pending settlement. Based on our experience to date, approximately 90 percent of disclosures involve hospitals.

Question. How many cases are within three months of reaching the four year look back period and in jeopardy of not reaching a settlement in time?

Answer. The four year look back period refers to the period of time during which a provider making a disclosure may not have been in compliance with the physician-self referral law, but is not a time limit for when a settlement must be reached. Once a provider of services or supplier electronically submits a disclosure under the Self-Referral Disclosure Protocol (SRDP) (and receives email confirmation from CMS that the disclosure has been received), the statutory obligation to return any potential overpayment within 60 days will be suspended until a settlement agreement is entered, the provider of services or supplier withdraws from the SRDP, or CMS removes the provider of services or supplier from the SRDP.

PACE

Question. Secretary Burwell, you recently announced your plans to move the Medicare program toward paying providers based on the quality, rather than the quantity, of care they give patients by shifting more Medicare dollars toward value based models. How will CMS account for Medicare Advantage plans and the PACE program as part of this initiative?

Answer. Medicare Advantage and PACE are a central part of the broader effort to increasingly shift Medicare to value-based payments. CMS will reach out to Medicare Advantage (MA) organizations to better understand the way they are using physician incentive payments (e.g. payments based on quality of care, patient satisfaction) and value-based contracting of provider services to achieve lower costs and improve quality of care, including reduced hospital readmissions and improved performance on specific health care measures. MA organizations have great flexibility to include incentives in their physician contracts, and many are employing methods to reduce costs, better coordinate care and promote better health outcomes.

Sponsors of Medicare Advantage and PACE plans are key participants in the Health Care Payment Learning and Action Network; through their participation, they will have the opportunity to learn about and potentially adopt value-based payment approaches being used in Medicare fee-for-service, employer/individual plans, and elsewhere. Also, Medicare Advantage and PACE plans will be able to share their experience in incentivizing quality and value for their enrollees.

In addition, the Center for Medicare and Medicaid Innovation is working on developing new payment and delivery models specifically focused on innovation in health plans. Public responses to a request for information issued in late 2014 generated valuable feedback to inform this work. Such payment and delivery models will further move Medicare towards value-based purchasing.

Question. In its fall 2012 Regulatory Agenda, CMS published a Notice of Proposed Rulemaking to revise the PACE regulation and noted it would be issued in July 2013. Since then, this deadline has been extended to December 2013, again to August 2014, and most recently, to Spring 2015. Will CMS issue a revised PACE regulation this spring?

Answer. CMS is currently performing a comprehensive review of the federal regulations governing PACE to identify potential regulatory changes to reflect the evolving needs and opportunities of the program. As CMS continues to contemplate potential regulatory changes, they have implemented a number of improvements to PACE, including streamlining the application process, updating the notification requirements for the use of alternative care settings, and establishing a new PACE council to bring together different components of the agency to focus on PACE issues.

SPECIAL NEEDS PLANS

Question. It is well known that a relatively small proportion of very sick, high-risk Medicare beneficiaries drive a significant proportion of the program's overall costs. Many of these chronically ill beneficiaries remain in unmanaged fee-for-service Medicare, despite the fact that their health outcomes could be substantially

improved if they were enrolled in a program that coordinated their care. Medicare Advantage (MA) plans, including Special Needs Plans (SNPs), provide this type of disease management and care coordination that both optimize health while reducing costs associated with unmanaged care and poorer outcomes. Recent cuts to MA plan payments jeopardizes this success.

Secretary Burwell, with the annual rate notice for MA plans coming out next week, what can you tell this Committee about the Agency's commitment to ensuring that robust disease management programs such as those provided by MA plans can continue to be available for chronically ill high-risk beneficiaries?

Answer. CMS will continue to promote robust disease management programs, such as those offered by Medicare Advantage (MA) plans, so they continue to be available for chronically ill high-risk beneficiaries. CMS continues to support MA organizations seeking to offer Special Needs Plans (SNPs), which provide this type of disease management and care coordination for those high-risk beneficiaries who qualify for these plans. CMS also encourages organizations to extend the disease management and care coordination efforts to all MA plans, not only SNPs. CMS requires MA organizations to make a best effort to conduct an initial assessment of each enrollee's health care needs within 90 days of the effective date of enrollment. CMS also requires SNPs to perform a comprehensive initial health risk assessment (HRA) that includes assessment of each enrollee's physical, psychosocial, and functional needs within the first 90 days of enrollment and conduct reassessments annually thereafter. HRAs used by MA organizations serve to identify beneficiaries at risk for disease, and MA organizations use these assessments to better target outreach and engagement efforts.

Furthermore, MA organizations must have an ongoing Quality Improvement (QI) program for each of their plans. A QI program is designed such that MA organizations have the necessary infrastructure to coordinate care, promote quality, performance, and efficiency on an ongoing basis. The HRA and QI programs are a few examples of programs used by MA organizations to improve disease management and care coordination for beneficiaries.

CMS believes care coordination and disease management are central tenets of the MA program and expects all MA organizations not only to continue to meet CMS's requirements related to care coordination and disease management, but to also improve upon existing efforts to optimize health while reducing costs associated with unmanaged care and poorer outcomes.

CO-OP FINANCIAL STATEMENTS

Question. As you know, HHS requires health insurance co-operatives to submit quarterly financial statements to the Centers for Medicare and Medicaid Services. On multiple occasions in recent months—including September 30, 2014, December 16, 2014, and January 11, 2015—Senate offices have asked for these quarterly reports, but not received them.

Have the state health insurance co-operatives been filing the reports as required? If so, why has CMS not provided this material on request to Senate offices?

Answer. To ensure strong financial management, CO–OPs are required to submit quarterly financial statements, including cash flow data, receive site visits by CMS staff, and undergo annual external audits, in order to promote sustainability and capacity to repay loans. This monitoring is concurrent with ongoing financial and operational monitoring by state insurance regulators.

CMS appreciates Congressional interest in the quarterly financial statements, and shares the goal of assuring that CO–OP loans are fully repaid. The quarterly financial reports contain extensive financial information, including assets, liabilities, revenue and expenses, and cash flow sheets. Additionally, premium, enrollment, and utilization information is found in the reports, as well as claims and underwriting information. As careful stewards of the federal funding invested in CO–OPs, CMS has an obligation to safeguard these reports, as the release of the proprietary information they contain could impede the loan recipients' ability to compete and thus imperil their ability to repay the loan amount to the federal government. These financial statements are not typically made public by privately held entities, which may be in direct competition with CO–OP issuers, and the disclosure of these materials could create undue harm to the CO–OPs, have an anti-competitive effect on the health insurance market in, and, as such, could prevent a CO–OP from repaying loans to the federal government.

CMS looks forward to continuing to work with Congress with respect to its interest in the CO–OP program, and to facilitate the success of the CO–OPs in providing an affordable and robust health insurance option for consumers.

QUESTIONS SUBMITTED BY HON. RON WYDEN

DELIVERY SYSTEM REFORM'S EFFECT ON CHRONIC CARE

Question. Over time, the Medicare program and providers have been increasingly focused on treating beneficiaries with chronic conditions such as cancer, diabetes and heart disease. I am determined to find a way to improve the care for chronically ill individuals, particularly Medicare beneficiaries.

The President's budget highlights the importance of our health care system rewarding providers that deliver high quality and coordinated care. Last week, you announced the Administration's, "Better Care, Smarter Spending" initiative, which sets goals and timelines so that more Medicare payments will be based on the quality and the care delivered, not just the number of services delivered. I have long believed we should move away from a volume-based system to one based on value. I believe we must also focus on the chronically ill who are most in need of care coordination and management. These are the patients most harmed by a fragmented health care system that works in silos, rather than teams. In order to reach the goals you've laid out, we're going to need to know what is working today.

How did you arrive at the goals and timelines you set for the "Better Care, Smarter Spending" initiative? What is the strategy to achieve these goals?

Answer. In setting goals and timelines, HHS wanted to be ambitious while also being realistic and to provide the private sector with a clear signal about Medicare's future direction.

Almost no Medicare fee-for-service payments were paid through alternative payment models (APMs) in 2011. This percentage increased to approximately 20 percent by the end of 2014 with a goal of 30 percent of payments in APMs by 2016 and 50 percent by 2018. This sends a clear signal about the importance of value-based payments in the future of Medicare. Additionally, for Medicare fee-for-service (FFS) payments linked to quality or value, HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018.

The strategy to reach these goals includes increasing enrollment in existing models, expansion of test models meeting the statutory requirements for expansion, and testing new APMs. The existing Medicare Shared Savings Program (MSSP) with Accountable Care Organizations (ACOs) continues to show success, with 89 new ACOs starting in 2015. Over 400 ACOs are now participating, serving more than 7.2 million beneficiaries. Additionally, a number of alternative payment models are being tested by the CMS Innovation Center including the Pioneer ACO, Bundled Payments for Care Improvement, and Comprehensive Primary Care models.

Question. How will you work with Congress on this initiative?

Answer. We look forward to working together with Congress as we continue our efforts to develop and test innovative payment and service delivery models. We continue to welcome congressional feedback and input. As we proceed with this initiative, we will keep Congress apprised of our progress and achievements.

Question. How do you plan to work with the private sector to achieve high, quality, high value care?

Answer. HHS plans to launch the Health Care Payment Learning and Action Network (Network), a collaborative network that will bring private sector payers, providers, and businesses together with consumers and public sector representatives to accelerate the transformation of the nation's health care delivery system to one that achieves better care, smarter spending, and healthier people, by supporting the adoption of alternative payment models through their aligned work. The goal of the Network is to provide a forum for public-private partnerships to help the U.S. health care payment system meet or exceed the recently established Medicare goals for value-based payments and alternative payment models.

Participants in the Network will meet and identify best practices related to alternative payment models. These best practices will be made available to individuals and organizations who are interested in learning more about value-based care and

alternative payment models. Through communication and collaboration, participants will have an opportunity to align on key characteristics of payment models that will facilitate the increased adoption of these models.

Question. Which Medicare and Medicaid programs are showing the most success at delivering high-quality, high-value care?

Answer. Early signs of the most success at delivering high-quality, high-value care are being demonstrated in the Pioneer Accountable Care Organization (ACO) initiative. The Pioneer ACO model has demonstrated that it's possible for providers to lower costs while improving quality. Preliminary results from the evaluation of the first performance year (2012) have shown that Pioneer ACOs achieved $147 million in savings in total spending above baseline and local market trends. At the same time, Pioneer ACOs had a mean quality performance score on 33 quality measures that increased from 71.8 percent in 2012 to 85.2 percent in 2013.

Other initiatives are also showing promising early results. Findings of the early effects of the Comprehensive Primary Care initiative (CPC) on service utilization and costs for attributed Medicare fee-for-service (FFS) beneficiaries through September 2013 are promising and more favorable than might be expected for the first 12 months of the initiative. Across all seven regions in the first year, early results suggest that CPC has generated enough savings in Medicare health care expenditures to nearly cover the CPC care management fees paid by CMS for attributed Medicare FFS beneficiaries. CPC also generated reductions in hospitalizations, outpatient ED visits, primary care physician visits, and specialist visits.

The Partnership for Patients initiative, launched in April 2011 with funds provided by the Affordable Care Act, aims to save 60,000 lives by averting millions of hospital acquired conditions over three years by reducing complications and readmissions and improving the transition from one care setting to another. At the core of this initiative are 26 Hospital Engagement Networks that work with 3,700 hospitals (representing 80 percent of the American population), working with health care providers and institutions, to identify best practices and solutions to reducing hospital acquired conditions and readmissions. As of December 2014, an HHS report shows an estimated 50,000 fewer patients died in hospitals and approximately $12 billion in health care costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2013. Preliminary estimates show that in total, hospital patients experienced 1.3 million fewer hospital-acquired conditions from 2010 to 2013, which translates to a 17 percent decline in hospital-acquired conditions over the three-year period.

Question. Which of your programs are targeting the chronically ill, and when will we see results from those programs?

Answer. Innovation Center models engage practices and serve beneficiaries whose needs range from the simple to the complex. Many Innovation Center models focus their efforts on chronically ill beneficiaries using one of two strategies. Models such as the Comprehensive Primary Care (CPC) Initiative and the Pioneer Accountable Care Organization (ACO) Model are structured in such a way that many practices and awardees have chosen to focus on the chronically ill as a means by which to achieve savings and show success in the program.

Another set of Innovation Center models are explicitly defined to meet specific needs of Medicare beneficiaries who are chronically ill and high utilizers of services. For example, the Comprehensive End Stage Renal Disease (ESRD) Care (CEC) Model is testing a new model of care delivery and payment for the segment of the Medicare fee-for-service (FFS) beneficiary population with ESRD. By creating incentives for dialysis facilities, nephrologists, and other Medicare providers of services and suppliers to collaboratively and comprehensively address the extensive needs of the complex ESRD beneficiary population, it seeks to improve outcomes for this population while reducing expenditures. We anticipate that the CEC model will begin in 2015.

HIT AND MEANINGFUL USE

Electronic health records and health information technology (HIT) have made huge advancements over the past decade and the Meaningful Use (MU) Program can largely be credited for that success. But we know that there is still a long way to go to reach the full value of HIT for both patients and providers. The MU program has had fits and starts along the way, but we know the administration, lawmakers and providers want the program to be successful to ensure the promise of electronically integrated information that will benefit providers and patients alike.

Recently, HHS announced it plans to propose more flexibility in the MU program, most importantly allowing for a shorter reporting period in 2015 for providers to meet MU, 90 days rather than 365 days.

Question. Can you explain the rationale for this decision?

Answer. CMS is working on multiple rulemaking tracks right now to realign the EHR Incentive Programs to reflect the progress toward program goals and be responsive to stakeholder input. CMS announced earlier this year that they are considering proposals to:

- Realign hospital EHR reporting periods to the calendar year to allow eligible hospitals more time to incorporate 2014 Edition software into their workflows and to better align with other CMS quality programs.
- Modify other aspects of the program to match long-term goals, reduce complexity, and lessen providers' reporting burdens.
- Shorten the EHR reporting period in 2015 to 90 days to accommodate these changes.

These intended changes would help to reduce the reporting burden on providers, while supporting the long term goals of the program.

The new rule, expected this spring, would be intended to be responsive to provider concerns about software implementation, information exchange readiness, and other related concerns in 2015. It would also be intended to propose changes reflective of developments in the industry and progress toward program goals achieved since the program began in 2011.

Question. Where do you see the MU program going so that providers and patients alike can receive value from their EHRs and their health information? What is your definition of success for the program?

Answer. To date, we have more than 414,000 providers who have earned an incentive payment for the adoption and meaningful use of certified EHR technology in the Medicaid and Medicare EHR Incentive Programs combined.

When the program first began we established the structure as a series of progressive milestones or benchmarks to encourage the adoption of certified EHRs rather than as a single goal. Stage 1 was focused on structured data capture, Stage 2 is focused on sharing that data and using health IT to support clinical processes, and Stage 3 will further focus on advanced use of EHRs for health information exchange, patient engagement, and quality improvement. Earlier this year we announced we would consider proposals to realign hospital reporting timelines with the calendar year and modify other aspects of the program to match long-term goals, reduce complexity, and lessen providers' reporting burdens. We also announced a proposal to transition from a full year to a 90 day reporting period in 2015 in order to accommodate these other changes.

Regarding the definition of success for the program, we began by focusing on obtaining success through adoption, and are moving toward focusing on obtaining success through the advanced use of certified EHR technology.

We have also identified progress towards key Stage 2 milestones, such as the exchange of health information and ensuring that patients have access to their records through an electronic means. We are focused on a continuous improvement model, with certified EHR technology as a foundation upon which delivery system reform can continue to build. We envision providers in all settings of care being able to freely exchange health information and patients having electronic access to their health information in order to facilitate engagement with their care team to make informed decisions about their health. We are placing emphasis on enhanced patient safety as functions such as clinical decision support interventions as well as electronic transmission of prescriptions and clinical orders to allow for improved real time checks within the clinical setting. Finally, we envision that the data available on quality and patient outcomes can help to inform best practice models and quality improvement initiatives to support chronic disease management, reduce health disparities, and ultimately improve health outcomes for patients.

We will know that we are successful when we see continued increase in the overall number of providers achieving Meaningful Use each year, improved performance over time, and an expansion in the meaningful use of certified EHR technology.

UNIQUE DEVICE IDENTIFIER (UDI)

Question. The FDA is establishing a national unique device identification system for medical devices, which will improve patient safety and quality of care. When the system is fully implemented, the label of most devices will include a unique device identifier (UDI). The device labelers must submit information about each device to the Global Unique Device Identification Database (GUDID), which will be publically accessible to all stakeholders to search and download information. However, there currently is no mechanism to capture the UDIs associated with patient claims data. While including UDIs in electronic health records may help better understand the safety and quality impacts of specific devices for individual patients, this mechanism does not allow for the aggregation or trending of data to identify safety or quality issues. While registries are a potential solution to this concern, they are unlikely to ensure the comprehensiveness that is needed. Integrating UDIs into administrative data would ensure comprehensiveness while also allowing for aggregation and trending over time. While this option would require administrative and claims data changes, it seems that the benefits of a claims option could greatly outweigh the administrative burdens, particularly over time as coding UDIs would become part of the regular process in claims processing.

As Medicare and the private sector continue to emphasize quality as their programs evolve, can you tell us the benefits of gathering UDI information?

Can you discuss the pros and cons of including UDIs for implantable devices in electronic health records?

Are there any significant barriers to including a data field on the standard administrative claims form that would allow for the collection of UDIs?

Can you discuss the pros and cons of including UDIs for implantable devices on Medicare claims data? What are your views on starting with a small number of the most relevant implantable devices?

Answer. HHS is committed to sharing information transparently to improve the quality and safety of care delivered to people across the country. The centerpiece—and most critical element—of post-market surveillance is the incorporation of UDIs into electronic health information; particularly electronic health records (EHRs) and device registries.

UDIs incorporated into EHRs would allow the use of a device to be linked with a patient's experience with that device, thereby generating better information for patients and providers to make well-informed decisions, and facilitate medical device innovation and safety surveillance. The FDA, the Office of the National Coordinator for Health IT (ONC), and the Centers for Medicare & Medicaid Services (CMS) are working closely on the shared goal of incorporating UDIs into EHRs, starting with implantable devices. UDIs incorporated into device or procedure-related registries could have similar benefits as those noted for EHRs. Registries could promote postmarket surveillance monitoring and quality by serving as a single location where robust information would be collected.

Key challenges include lack of standardized capture of the UDI on the label at point of care (POC), a challenge that also applies to claims reporting, and obstacles to electronic transmission of the UDI (e.g., from EHRs to registries). Professional societies, as they either modify or develop their registries, are increasingly enabling POC-capture of UDIs. Consistent with the National Medical Device Postmarket Surveillance System, the FDA continues to promote registry development, both domestically and through international consortia. Additionally, standards development organizations are tackling how to standardize data transmission.

Some have suggested that incorporating UDIs into claims could also facilitate device safety analysis. As a first step, the American National Standards Institute's Accredited Standards Committee (ASC X12), the body that develops and maintains electronic data interchange standards, is exploring business cases for including UDIs into health care transactions. Both CMS and FDA are participants and look forward to continuing working through these issues at the ASC X12 Committee. HHS also supports the recommendations by the National Committee on Vital and Health Statistics to consider conducting voluntary pilot tests of the benefits, costs, and feasibility of UDIs in claims reporting between providers and commercials payers. Voluntary pilots should address key challenges to adding UDIs to claims including significant technological hurdles and costs (for providers, payers and others), as well as difficulties in validating UDIs reported on claims.

BENEFITS OF THE MEDICAID EXPANSION AND LOST OPPORTUNITIES

Question. There are still 22 states that have not expanded Medicaid. Medicaid dollars flow directly to health care service providers such as physicians, hospitals, and nursing facilities—further bolstering job growth in these sectors and having positive indirect effects in other sectors of the economy. In 2013, the Kaiser Family Foundation reviewed over 30 studies that universally showed Medicaid's simulative impact on state economies. The President's Council of Economic Advisers has also noted that Florida and Texas alone would see over 33,000 new jobs in 2016 if they expanded their Medicaid programs. These findings and others strongly suggest that the states avoiding Medicaid expansion are missing out on considerable economic opportunities.

Can HHS elaborate on the different ways Medicaid expansion might help bolster state economies and create jobs?

Answer. HHS is eager to work with all states to expand Medicaid so that they can take advantage of federal funding provided under the Affordable Care Act. The Administration believes that consumers with health insurance have better access to health care, get more preventive screening and are financially protected in the event of a health emergency. If non-expansion states reversed their decision, 255,000 fewer consumers would face catastrophic out-of-pocket medical costs and 810,000 fewer consumers would have trouble paying other bills because of the burden of medical costs.[40] Pre-Affordable Care Act (ACA) Medicaid expansions have been associated with significant reductions in consumer bankruptcy rates.[41] State residents with a more secure financial future are more productive workers, face less mental health concerns like depression, and are able to invest in their education, business or retirement.

Evidence suggests that Medicaid expansion is financially beneficial to health care providers like physicians and hospitals. Recent HHS analysis indicated that hospitals in Medicaid expansion states have seen larger drops in uninsured/self-pay admissions and emergency department visits than those in non-expansion states.[42] When provider balance sheets improve, they are able to grow their business and hire more staff. Fitch Ratings, a financial information services firm, recently released findings that healthcare jobs grew faster in states that expanded Medicaid under the Affordable Care Act than those that did not.[43] Further, analysis from the President's Council of Economic Advisors demonstrated that expansion would have boosted employment in non-expansion states by 85,000 jobs in 2014 and 184,000 jobs in 2015.[44]

States that have secure and healthy workforces, along with strong healthcare sectors, are ripe for investment and job growth. HHS stands ready to work with those states that wish to take advantage of this important opportunity and expand high-quality, affordable coverage under Medicaid.

Question. Is any information forthcoming from HHS (or elsewhere in the Administration) on the impact of Medicaid on the overall economy?

Answer. Yes, the Department is examining the economic impact of the Medicaid expansion, and we will be happy to share the results of that work once it is completed. Additionally, in July 2014 the Council of Economic Advisors released a report titled: "Missed Opportunities: the Consequences of State Decisions not to Expand Medicaid."[45]

BENEFITS OF MEDICAID FOR CHILDREN

Question. According to a new study from the National Bureau of Economic Research, when kids have Medicaid they are more likely to earn higher wages and pay higher federal taxes when they become adults. This is great news for them and also the economy and our federal budget.

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[40] *https://www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid_0.pdf.*

[41] Gross, T. and Notowidigdo, M. (2011). Health Insurance and the Consumer Bankruptcy Decision: Evidence from Expansions of Medicaid. Journal of Public Economics 95(7–8): p. 767–778: *http://www.sciencedirect.com/science/article/pii/S0047272711000168.*

[42] *http://aspe.hhs.gov/health/reports/2014/uncompensatedcare/ib_uncompensatedcare.pdf.*

[43] *https://www.fitchratings.com/gws/en/fitchwire/fitchwirearticle/Healthcare-Jobs-Grew?pr id=980053&cm_sp=homepage-_-FitchWire-_-Fitch:%20Healthcare%20Jobs%20Grew%20Faster %20in%20ACA%20Expansion%20States.*

[44] *https://www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid_0.pdf.*

[45] *https://www.whitehouse.gov/sites/default/files/docs/missed_opportunities_medicaid_0.pdf.*

Can HHS provide more detail on how Medicaid enrollment might lead to both longterm gains in revenue and benefits to child enrollees?

Answer. Medicaid and the Children's Health Insurance Program (CHIP) are vital sources of health coverage for our nation's children. The programs offer high-quality care and financial protection from unaffordable health care bills. As you mentioned, the National Bureau of Economic Research recently found that Medicaid has positive long-term effects on mortality, amount of federal taxes paid and college attendance. Because of these benefits, the study also concluded that the government will recoup 56 cents of each dollar spent on childhood Medicaid by the time these children reach age 60.[46] This research adds an important perspective to the ongoing discussion on Medicaid's effectiveness and we look forward to future research demonstrating the programs' positive impacts.

CARE PLANNING IN MEDICARE

Question. The Advisory Council on Alzheimer's Research, Care, and Services makes recommendations to HHS on how to improve care for individuals, including Medicare beneficiaries, living with Alzheimer's and other dementias. The Advisory Council's 2014 recommendations included the following recommendation: "CMS should redesign Medicare coverage and physicians' and other health care providers' reimbursement to encourage appropriate diagnosis of Alzheimer's disease and to provide care planning to diagnosed individuals and their caregivers."

How can effective care planning improve care for patients with Alzheimer's and other chronic diseases like cancer or diabetes?

Do you agree that Medicare can promote better care coordination if care planning for Alzheimer's patients were covered and reimbursed?

Do you think that care planning could promote better care coordination for all beneficiaries with a chronic disease?

Answer. CMS wants providers to have the resources and information they need to coordinate patient care.

Chronic illnesses, such as Alzheimer's, heart disease and diabetes, can be a major detriment to beneficiaries' quality of life and generate significant expense for the Medicare program. In 2010, the 37 percent of Medicare beneficiaries who were treated for four or more chronic conditions accounted for 74 percent of all Medicare expenditures.

The goal of coordinated care is to make sure that beneficiaries, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. Beneficiaries, their families, doctors, and taxpayers will all benefit as we move our health care delivery system towards more coordinated care.

CMS is working through a variety of programs and demonstrations to test models of care and the effectiveness of coordinated care for high-risk beneficiaries. One such model is the Medicare Coordinated Care Demonstration.[47] While this demonstration produced mixed results, it has helped to inform CMS as they continue to look for ways to improve care for beneficiaries and while producing savings for the Medicare trust funds.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING (MIECHV)

Question. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program that serves so many families and children has enjoyed bipartisan support because it embraces a common sense idea. It provides states with the resources to design programs that they think work best for their communities to strengthen families and save money. For example, I know in my home state of Iowa, the MIECHV Program has helped participating vulnerable families move toward self-sufficiency. In fact, 86% of enrolled families have demonstrated an increase in income and are better off now than when they started participating. Congress needs to extend the program by March 31, and I look forward to working with my colleagues on the Fi-

[46] *http://www.nber.org/papers/w20835.*
[47] *http://innovation.cms.gov/Files/reports/MedicareCoordinatedCareDemoRTC.pdf.*

nance Committee to get the job done. We all stand to benefit from this continued wise investment in our families.

Secretary Burwell, can you speak to the effective services that families are receiving as a result of the MIECHV Program and the likelihood that this program will produce good outcomes for children and savings to the taxpayer?

Answer. The Home Visiting Program funds states, territories, and tribal entities to develop and implement evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry. The program builds upon decades of scientific research showing that home visits by a nurse, social worker or early childhood educator during pregnancy and in the first years of life improve the lives of children and families by preventing child abuse and neglect, supporting positive parenting, improving maternal and child health, and promoting child development and school readiness. Research has also shown that evidence-based home visiting is a good investment for taxpayers, as it can provide a positive return on investment to society through savings in public expenditures on emergency room visits, child protective services, special education, as well as increased tax revenues from parents' earnings. In fiscal year (FY) 2014, states reported serving approximately 115,500 parents and children in 787 counties in all 50 states, the District of Columbia, and five territories through the Home Visiting Program. Since 2012, the Home Visiting Program has provided more than 1.4 million home visits, building strong, positive relationships with families who want and need support. In FY 2014, tribal grantees reported serving about 2,800 children and families as a result of the Tribal Home Visiting Program and tribal grantees have provided nearly 18,000 home visits since the start of the program. For more information on the Home Visiting Program, including outcomes for children, please see the recently released fact sheet entitled, *The Maternal, Infant, and Early Childhood Home Visiting Program Partnering with Parents to Help Children Succeed,* available at HRSA.gov.

SUNSHINE ACT IMPLEMENTATION

Question. Last year, rollout of the Open Payments website by CMS involved multiple challenges and technical problems, such as the incorrect attribution of payment data that resulted in a decision by CMS to publish a substantial amount of data in de-identified form.

What steps are CMS taking to ensure that the same technical problems will not occur this year?

Answer. Last year, CMS identified payment records submitted by the applicable manufacturers and group purchasing organizations (GPOs) that had inconsistent physician information, such as National Provider Identifier (NPI) for one doctor and a license number for another. CMS took the Open Payments system offline on August 3, 2014 to resolve these data integrity issues and reopened the system on August 14, 2014. During this period, CMS worked to verify that the physician and teaching hospital identifiers reported by applicable manufacturers and GPOs matched data in CMS or external data sources. This matching verified that payment records were attributed to a single, consistent physician or teaching hospital. Because these records represent payments that were actually made and legally attested to by the submitting company, they are available on the public website, but they are de-identified by suppressing physician or teaching hospital identifying information. To provide as complete a data set as possible to the public, CMS published both "identified" and "de-identified" data.

On October 30, 2014, CMS made a non-public, downloadable Validated Physician List available to applicable manufacturers and GPOs in the Open Payments system. This list contains variations of physician identifier information for physicians to whom payments were reported in the Open Payments system in 2013, and is provided to assist with data matching. Many of the inconsistencies identified in the returned records were a result of physician identifiers not matching against CMS or external data sources. CMS has encouraged applicable manufacturers and GPOs to use the provided physician list to avoid further inconsistencies in data reporting. CMS anticipates releasing similar lists for upcoming years for industry use.

To correctly attribute records to covered recipients, CMS has created covered recipients profiles based on the data in the National Plan & Provider Enumeration System (NPPES) and the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). All payments or other transfers of value and ownership or investment interest records reported by applicable manufacturers and GPOs are then validated using these profiles. Incoming records that contain incongruent identifying in-

formation about covered recipients are rejected before entering the system and returned to the applicable manufacturer or GPO for correction.

CMS has also provided applicable manufacturers and GPOs with numerous aids and guides to assist with data submission. These support materials included the annually-updated teaching hospital list, submission data mapping documents, sample submission files, the Open Payments System User Guide, step-by-step detailed instructions, and quick reference guides.

340B

Question. It was anticipated that last year, the Health Resources and Services Administration (HRSA) would submit updated regulations concerning the 340B drug program. Those regulations have not been released.

Does HRSA intend to issue regulations concerning 340B? If yes, what is the status of that regulation? If no, does HRSA plan to issue guidance on the 340B program in FY 2015?

Answer. In 2014, HRSA planned to issue a proposed omnibus regulation for the 340B Program to establish additional clear, enforceable policy to advance our oversight of covered entities and manufacturers. In May 2014, while the omnibus proposed regulation was under review within the Administration, the U.S. District Court for the District of Columbia issued a ruling addressing an earlier 340B regulation concerning orphan drugs (certain drugs used to treat rare conditions or diseases). The court invalidated the orphan drug regulation, finding that HRSA lacked explicit statutory authority to issue it. In light of this ruling, HRSA will issue proposed rules where the statute is specific about rulemaking and provide revised guidance to address critical policy matters raised by 340B Program stakeholders for which there is a lack of explicit regulatory authority. The guidance will enable covered entities and manufacturers fully comply with statutory 340B Program requirements and will increase the Department's ability to ensure effective implementation, oversight, and monitoring of the 340B Program.

There are three areas of the 340B statute where HRSA has explicit regulatory authority: calculation of 340B ceiling prices; imposition of manufacturer civil monetary penalties; and implementation of a dispute resolution process. HRSA expects to release Notices of Proposed Rulemaking this year on these three issues. HRSA intends to release a proposed omnibus guidance for public notice and comment later this year. HRSA will review and consider public comments, and finalize the regulations and guidance.

Question. How many audits did HRSA conduct of 340B hospitals in FY2014, and what were the results of the audits?

Answer. HRSA applies a risk-based model taking into consideration multiple factors when determining which entities to audit in any given year. These factors include the length of time a covered entity has been in the program, the number of associated sites, volume of purchases, and the number of contract pharmacies. There are also entities selected on a targeted basis, meaning that HRSA has information regarding potential compliance issues that require further review. In FY 2014, HRSA conducted 99 audits covering 1,476 outpatient facilities and 4,028 contract pharmacies. Eighty of the 99 audits (81 percent) conducted in FY 2014 were conducted at 340B participating hospitals and approximately 43 of these 80 have been finalized. The remaining 340B audits on participating hospitals are in various stages of being finalized with the covered entities. Of the 43 finalized, 28 percent had no findings. The remaining 72 percent had a range of findings and are required to submit a corrective action plan to come into full compliance and remedy any issues. These findings include:

- 37 percent had eligibility findings (i.e., database record errors, including incorrect contact information);
- 44 percent had diversion of 340B drugs to non-340B patients; and
- 19 percent did not have mechanisms in place to prevent duplicate discounts.

These audit findings are made available to the public on HRSA's website. Once an audit is completed and the covered entity agrees with the adverse findings, the covered entity has to submit a plan for future compliance, including items such as correcting database errors, training of staff, improving policies and procedures and correcting system errors. The plan may also include repayment to affected drug manufacturers, if applicable. All corrective action plans must be approved by HRSA.

HRSA monitors the covered entity during the course of implementation and closes the audit upon completion of the corrective action plan.

Question. How many audits did HRSA conduct of pharmaceutical companies for 340B compliance in FY2014, and what were the results of the audits?

Answer. HRSA, in partnership with the OIG, is currently conducting an audit of a manufacturer. Once an audit is complete, the summary information will be posted on HRSA's website. HRSA developed a protocol for auditing manufacturers later this fiscal year.

Question. Please describe the oversight activities HRSA took in FY 2014 over the 340B drug program and planned oversight activities for FY 2015.

Answer. HRSA places a high priority on the integrity of the 340B Program and has strengthened oversight of this program, particularly in the last four years. As part of our oversight of the program, HRSA verifies that both 340B-covered entities and manufacturers are in compliance with 340B Program requirements. As a result of our enhanced focus on compliance issues, there has been more attention paid to compliance of program requirements by covered entities, which has resulted in increased self-disclosures and voluntary terminations initiated by the covered entities when requirements were not being met. In order to augment these efforts, the Congress provided HRSA with an additional $6 million in the Consolidated Appropriations Act for FY 2014. This funding has enabled HRSA to:

- Improve information technology (IT) systems to more effectively track entity and manufacturer compliance;
- Increase the number of audits performed on covered entities and manufacturers in order to ensure compliance; and
- Hire additional auditors and staff to implement new IT investments for expanded program integrity efforts.

HRSA ensures manufacturer compliance through development of guidances (including issuance of forthcoming omnibus proposed guidance) and policy releases. Additionally, HRSA verifies manufacturers in Medicaid have signed a pharmaceutical pricing agreement, reviews all allegations brought to our attention, requires refunds when a covered entity is overcharged, and undertakes manufacturer audits, beginning with the one currently underway and furthered by ongoing work on an auditing protocol.

As noted previously, HRSA conducted 99 covered entity audits encompassing 1,476 outpatient facilities and 4,028 contract pharmacies in FY 2014.

HRSA plans to audit approximately 200 covered entities in FY 2015. For FY 2015, HRSA has already completed 51 on-site audits of covered entities encompassing 926 outpatient facilities and 2,114 contract pharmacies. As of March 30, 2015, seven FY 2015 audits have been finalized and are posted on the HRSA website.

MEDICARE AND MEDICAID IMPROPER PAYMENT

Question. Improper payment rates for Medicare increased in FY2013 and FY 2014. In Medicare Fee-for-Service, the amount of improper payments increased from a low of $29.6 billion in 2012 to $36 billion in 2013 and $37.3 billion in 2014.

Why are improper payment rates increasing?

Answer. HHS shares your concerns and we strive to be good stewards of taxpayer and trust fund dollars. It is important to remember that not all improper payments are necessarily fraudulent. Like other large and complex Federal programs, Medicare, Medicaid, and CHIP are susceptible to payment, billing, coding and eligibility errors referred to as "improper payments." While improper payments are not necessarily indicative of fraud, HHS is committed to reducing all waste within our programs.

The primary causes of Medicare FFS improper payments are insufficient documentation and medical necessity errors. A large driver of this year's increase in the Medicare FFS improper payment rate was insufficient documentation for home health claims. It can take time for providers and suppliers to fully comply with new policies, especially those with new documentation requirements, which can increase the improper payment rate until full compliance is achieved.

Question. What actions does HHS plan to take to address the increase in improper payments made?

Answer. In all, Medicare receives about 3.3 million fee-for-service claims each day, or 1.2 billion claims a year. Due to the high number of claims, HHS is committed to paying claims in an accurate and timely manner and has a comprehensive strategy in place to address the Medicare improper payment rates. For the Medicare program, these strategies include strengthening provider enrollment safeguards to confirm only legitimate providers are enrolled and preventing improper payments by using edits to deny claims that should not be paid. HHS also develops targeted demonstrations in areas with consistently high rates of improper payments and operates a Medicare fee-for-service Recovery Audit Program to identify, recover, and prevent improper payments.

HHS has developed targeted demonstrations to reduce improper payments for items and services at high risk for fraud, waste, and abuse, such as Power Mobility Devices (PMDs), where HHS found that over 80 percent of claims for PMDs did not meet Medicare coverage requirements.[48] HHS implemented the Medicare Prior Authorization of PMDs Demonstration in seven high risk states in September 2012.[49] Since implementation, HHS has observed a decrease in expenditures for PMDs in both demonstration and non-demonstration states. Based on claims processed as of November 14, 2014, monthly expenditures for the PMDs included in the demonstration decreased from $20 million in September 2012 to $6 million in June 2014 in the non-demonstration states and from $12 million to $3 million in the demonstration states.[50] HHS expanded the demonstration to an additional 12 states on October 1, 2014.[51]

HHS is also testing whether prior authorization helps to reduce unnecessary expenditures, while maintaining or improving quality of care. HHS issued a proposed rule in May 2014 to establish a prior authorization process for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items that are frequently subject to unnecessary utilization. Additionally, HHS recently implemented a prior authorization model for repetitive scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, and South Carolina.[52] HHS will also begin implementing a prior authorization demonstration program for non-emergent hyperbaric oxygen therapy in Illinois, Michigan, and New Jersey.[53] HHS believes using a prior authorization process will help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid. The President's FY 2016 Budget includes a proposal that would build on the success of the prior authorization demonstrations by giving CMS the authority to require prior authorization for all Medicare fee-for-service items that it determines are at the highest risk for improper payments.

Question. How has the Recovery Audit Contracting program impacted improper payment rates within Medicare?

Answer. The Recovery Audit Program identifies areas for potential improper payments and offers an opportunity to provide feedback to providers on future improper payment prevention. HHS uses Recovery Auditors to identify and correct improper payments by reviewing claims. HHS responds to the vulnerabilities identified by the Recovery Auditors by implementing actions that will prevent future improper payments nationwide. Since full implementation in FY 2010 through the fourth quarter of FY 2013, the Recovery Auditors have returned over $5.4 billion to the Medicare Trust Fund. Additionally, MACs review claims and conduct provider education to help providers avoid documentation errors and other sources of improper payments, including articles or bulletins providing narrative descriptions of the claim errors identified and suggestions for their prevention. Other efforts include system edits for improper payments that can be automatically prevented prior to payment. HHS encourages collaboration between Recovery Auditors and MACs to discuss improve-

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[48] *http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf.*

[49] The seven states are: CA, IL, MI, NY, NC, FL and TX.

[50] *https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/PMDDemoDecemberStatusupdate12302014.pdf.*

[51] *http://www.gpo.gov/fdsys/pkg/FR-2014-07-29/pdf/2014-17805.pdf;* the twelve states are: AZ, GA, IN, KY, LA, MD, MO, NJ, OH, PA, TN, and WA.

[52] *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-of-Repetitive-Scheduled-Non-Emergent-Ambulance-Transport-.html.*

[53] T3http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-of-Non-emergent-Hyperbaric-Oxygen.html.

ments, areas for possible review, and corrective actions that could prevent improper payments.

TELEHEALTH AND RURAL HEALTHCARE

Question. Through telemedicine, Iowans in rural parts of the state can access specialists in their home-communities, instead of traveling to a big city for an appointment. Telemedicine saves patients in rural America time and money. Unfortunately, there seems to be a disconnect in the eligibility criteria for facilities that want to use this technology for their Medicare population. CMS guidelines stipulate that a hospital must be located outside an urban Metropolitan Statistical Area (MSA) in order to be an originating site (which is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs). CMS also indicates that Critical Access Hospitals (CAH) are eligible to be originating sites.

The problem arises when a hospital is technically located in an urban MSA, but through proper procedures and channels has obtained the designation of a CAH. For example, Madison Country Memorial Hospital, located in Madison County IA is considered to be located in an urban MSA. However, in 2005 they received authorization from CMS to be re-classified as a rural hospital and subsequently designation as a CAH. Recently, they looked into offering telehealth services to their Medicare patients and discovered they were unable to do so because of the urban MSA rule, despite their designation as a CAH. Hospitals in urban MSAs are allowed to re-classify as rural hospitals for a reason: they serve a community that is, under other considerations, rural.

Do you believe hospitals in these, and similar circumstance, should have the opportunity to provide telehealth services to their Medicare population?

Answer. CMS must comply with statutory requirements related to the sites eligible to furnish telehealth services. The law only allows telehealth services to be furnished from originating sites that are located in rural areas or rural health professional shortage areas (HPSA). CAHs have a rural location requirement: the law requires that CAHs either be physically located in a rural area or that they reclassify as rural. Therefore, some facilities are located in urban areas but have been able to obtain designation as CAHs because they have reclassified as rural. One way in which a facility can reclassify as rural for purposes of meeting the CAH rural location requirement, is if it is located in a rural census tract of an MSA. However, CAHs do not have to be located in an area that is a HPSA.

As in this case, if the rural census tract of an MSA is not a HPSA, the CAH does not meet the statutory requirement for being a telehealth originating site. The statutory provisions applicable to telehealth originating sites are based on the physical location of the site.

Question. Is this discrepancy something Congress needs to fix, or do you have any latitude in the matter?

Answer. CMS pays for telehealth services in accordance with the statute. We are willing to work with Congress to provide technical assistance on proposals to change the law.

DRUGS FOR THE TREATMENT OF OBESITY

Question. The amount of money our country spends to combat obesity and diabetes is incredible. But there are ways to address both, like counseling those with diabetes regarding diet and exercise and coverage for a new spate of FDA-approved drugs to treat obesity. These efforts do require spending. But these are investments that will drive reductions in the incidence of obesity and diabetes and their related co-morbidities such as certain cancers, heart disease, hypertension, and end stage renal disease to name a few. Undoubtedly, a reduction in obesity and diabetes will lead to healthier individuals—which should cost Medicare and Medicaid less money over the long term.

So I was disappointed to receive your letter in December 2014 indicating that you do not believe existing statute "could be construed to permit basic Part D coverage to include FDA-approved weight loss drugs used to treat obesity" and that Part D coverage for such products "would require a legislative change passed by Congress." I hope this Committee will move such legislation this year.

In terms of your offer for HHS to provide technical assistance on this matter, can you please report back to the Committee both legislative technical assistance based

on the bills from the 113th Congress (S. 1184 and HR 2415) as well as provide any estimates of potential cost savings to the Medicare and Medicaid programs if the incidence of obesity and diabetes were reduced and/or delayed?

Answer. We welcome the opportunity to work with you to provide technical assistance on this important issue. As you noted, counseling on diet and exercise is critically important for those with diabetes. Medicare covers diabetes self-management training for diagnosed diabetics, as well as diabetes screening tests for those with risk factors for diabetes (including obesity). Medicare also covers medical nutrition therapy for persons diagnosed with diabetes or renal disease. In addition, Medicare covers intensive behavioral therapy for obesity in primary care settings. The availability and importance of these services would also be highlighted, as appropriate, in the one-time "Welcome to Medicare" visit and the Annual Wellness Visit. Under Medicare Part D, each Part D sponsor must have a Medication Therapy Management program for beneficiaries with multiple chronic conditions such as diabetes. Medication Therapy Management services include interventions for beneficiaries and prescribers; an annual comprehensive medication review which is an interactive, person-to-person, or telehealth consultation performed by a pharmacist or other qualified provider for the beneficiary; and quarterly targeted medication reviews with follow-up interventions when necessary. CMS also encourages sponsors to offer Medication Therapy Management services to beneficiaries who fill at least one anti-hypertensive medication, to support the Million Hearts Initiative.

MEDICARE PART D AND NETWORK PHARMACIES

Question. During the 2015 open season, many pharmacies were listed on Medicare's plan finder and on Aetna's website as being in network that were in fact out of network, creating chaos for both pharmacies and their patients. A very large concern is the worry that this could happen again.

Were you aware that out of network pharmacies were listed on Medicare's plan finder and on Aetna's website as in network?

Answer. Aetna disclosed to CMS that a total of 6,887 pharmacies were erroneously identified by Aetna as "retail in-network" for 2015 on its website and through its call center customer service representatives during the CY 2015 Annual Election Period. Once CMS became aware of the issues that Aetna's pharmacy contracting strategy created, CMS issued a compliance action requesting Aetna to implement a Corrective Action Plan (CAP) on January 28, 2015.

Question. What will be done to ensure something like this doesn't happen again?

Answer. In Aetna's Corrective Action Plan request letter, CMS advised Aetna that its CAP should include plans for making certain that any Part D pharmacy contracting process it may adopt for the 2016 plan year is compliant with the CMS requirements. Also, CMS will review its experience with Aetna's plan year 2015 Part D pharmacy contracting process to determine what additional oversight might be appropriate to make certain that beneficiaries and pharmacies are correctly and fully informed of Aetna's (or any other Part D sponsor's) network pharmacy arrangements for 2016.

STATE MARKETPLACES

Question. Currently the question of subsidies available to beneficiaries through federally facilitated marketplaces is being considered before the Supreme Court.

If a state with a federally facilitated marketplace asked HHS/CMS to deem that marketplace to serve as their state-based marketplace, does HHS/CMS have the authority to grant that request?

Answer: We have previously provided public guidance with regard to the process that states need to follow if they choose to operate a state based marketplace and are willing to assist any state that would like to do so.

QUESTIONS SUBMITTED BY HON. MICHAEL F. BENNET

Question. While plans on the Exchanges limit out-of-pocket maximums, a large amount of discretion is left up to States to set limits on exorbitantly high co-pays, co-insurance, and deductibles. Unfortunately, I've seen some plans in Colorado with deductibles as high as $6000 for an individual, and $12,000 for a family. Often, these plans are combined with 30–40% co-insurance for specific services, which can make them too expensive for a middle-class family.

Given that the transparency of pricing in our health care system is still woefully inadequate, I wanted to know how much HHS is monitoring this and ensuring that families that are on the Exchange feel confident that we're taking steps to give these Colorado families the security they need.

Answer. The Affordable Care Act is delivering on the promise of access to high quality, affordable health care coverage, while controlling the growth of health care costs. The creation of a successful, viable health insurance market has benefits for all Americans no matter where they get their health insurance.

There are five categories or "metal levels" of coverage in the Marketplace. Plans in each category pay different amounts of the total costs of an average person's care. This takes into account the plans' monthly premiums, deductibles, copayments, coinsurance and out-of-pocket maximums. Metal levels range from bronze, in which the health plan pays 60 percent of care costs on average, to platinum, in which the health plan pays 90 percent of care costs on average. Catastrophic plans, in which plans pay on average less than 60 percent of care costs on average and the consumer pays low premiums but have high deductibles, are also available in the Marketplace. Consumers with low and middle incomes may qualify for advance premium tax credits to help lower their monthly premium costs and cost sharing reductions through the Marketplaces to help with out of pocket expenses like copayments and deductibles.

When choosing their health care coverage, consumers must consider factors like the frequency of doctor visits and their need for regular prescriptions. Although it may be impossible for families to predict their health care needs, HHS is confident that they will be able to find a high quality, affordable health insurance plan that will meet their needs.

Question. I saw that the HHS budget has new proposals on child welfare and foster care. As you know, this is a highly vulnerable population, and these children need stability and resources in areas with proven outcomes.

Given the focus on this area in your budget, can you share additional background on the Administration's plans to invest more in prevention and permanency through evidence-based programs?

Answer. Overall, the use and development of evidence-based programs and interventions has the potential to ensure effective practice that improves outcomes for families and children. Below, we provide specific explanations of how evidence-based practice factors into the child welfare proposals:

Title IV–E for Prevention and Permanency Services: We propose to allow title IV–E agencies to claim federal reimbursement for pre-placement and post-placement services included as part of the child's case plan for candidates for foster care at 50 percent FFP (the same rate as administrative costs). A majority of such funds must be used for evidence based/informed interventions as defined by the Secretary. Currently, states face challenges in providing evidence based/informed services statewide because of the cost and the availability of providers trained in these practices. Therefore, we estimate that 7.5 percent of services that child welfare agencies currently provide would fall within the standards required under the proposed approach, and expect the percentage will gradually increase over the next ten years with the availability of IV–E funding for this type of service.

Demonstration to Address the Over-Prescription of Psychotropic Drugs for Children in Foster Care: This proposal will include the development and scaling up of screening, assessment, and evidence-based treatment of trauma and mental health disorders among children and youth in foster care with the goal to reduce the inappropriate reliance on psychotropic medications and improve child and family well-being. Youth in foster care have enough challenges without being overly or inappropriately medicated. The existing evidence-base in the area of trauma-informed psychosocial interventions warrants a large initial investment to expand access to effective interventions.

Reauthorize, Modify, and Re-name the Abandoned Infants Assistance Act to "Protecting At-Risk Infants and Toddlers Act": The demonstration will support the development of evidence based interventions that can safely prevent entry into out-of-home care as well as interventions that meet the unique needs of infants and toddlers who do enter care. Data from the National Survey of Child and Adolescent Well-Being notes that many parents coming into contact with the child welfare system with infants and toddlers are referred to parenting classes, of which there is little efficacy evidence on their ability to provide appropriate parenting support to

families facing so many challenges. The field is also lacking strong empirical information on how to best serve the needs of mothers facing domestic violence. The Institute of Medicine's 2013 report, New Directions in Child Abuse and Neglect Research, notes a critical need to build a body of empirical evidence on what strategies work for this population. This demonstration program will address the needs of families with infants and toddlers and simultaneously test the efficacy of strategies at all levels of prevention.

Question. Also, would you be willing to work with my office to determine the financial impact of shifting children from congregate care to family foster care and how this affects outcomes?

Answer. Yes, we would be happy to work with your office on the financial implications of the family-based care proposal. This proposal is estimated to cost $78 million in FY 2016 and reduce costs of title IV–E foster care by −$69 million over ten years. The Administration's cost estimate assumes that the proposal will increase the availability of family-based care and, as a result of establishing and enhancing those services, states will move children from congregate placements to family settings to better meet the needs of children while reducing the costs for IV–E.

Title IV–E agencies will be reimbursed with 50 percent federal financial participation (FFP) for administrative activities associated with this oversight and eligibility documentation components of the proposal. This rate is the same as current law, but we estimate that IV–E agencies will have higher claims for eligibility determination activities to implement and comply with the new requirements for documenting the justification for congregate care settings and acquiring judicial determinations every six months. We assume that the additional claims related to this new procedure will decline as the congregate care placements decline following the implementation of the supports for family-based care.

The Children's Bureau, within the Administration for Children and Families, produced a data brief that examined how, when, and for whom congregate care is being used in the child welfare system (*http://www.acf.hhs.gov/programs/cb/resource/congregate-care-brief*). The brief highlights that seventy percent of children and youth in congregate care are age 13 and older. Most of the youth in congregate care had a DSM diagnosis, physical disability or entered care due to a child behavior problem. Some of these children and youth were initially placed into congregate care for treatment; others were subsequently placed in congregate care because they were not able to remain in a traditional foster family care placement.

The proposal seeks to reduce use of congregate care while improving outcomes for children in two ways. First, the proposal promotes family-based care for children who have been traditionally placed in congregate care due to youth's complex needs through increased investments in alternative interventions, specialized caseworker and foster parent training, increased foster parent reimbursement for those providing specialized care to high-need children and day treatment programs.

In addition, the proposal promotes family-based care, through increased oversight, for those children in congregate care, including those who have no apparent clinical indicators. In 2013, there were 15,000 children (29 percent) who were placed in a congregate care setting but had no identifiable clinical indicators.

Second, the proposal creates a new eligibility requirement under title IV–E requiring documentation to justify congregate care as the correct foster care placement setting, based on the child's mental, behavioral or physical health needs and the congregate care provider's ability to address those needs. The oversight requirements will both require more careful scrutiny of the appropriateness of these placements and give states a financial incentive to ensure that residential care placements are used appropriately and only for as long as the specific interventions provided in the placement are necessary. This proposal would require states to review case plans for all children currently in congregate care, and moving children who do not have clinical needs out of congregate care and new children entering congregate care setting. The goal is that children are only placed in congregate care, when it is medically appropriate, and determined to be the least restrictive foster care placement setting. In order to support family based care for children with complex needs, the President's budget proposal increases reimbursement for specialized caseworker training and case management, increases reimbursement for foster parent who provide therapeutic care and provides additional reimbursement for day treatment.

Question. In my home state of Colorado, the population of seniors choosing Medicare Advantage is rising. About 250,000 Coloradans representing nearly 35% of all

beneficiaries in the state are in a Medicare Advantage plan. I want to ensure that seniors across my state continue to have their choice of providers and Medicare Advantage plans no matter their health status. One of the concerns I have involves CMS' discretion in implementing Medicare Advantage's risk adjustment. For 2014, CMS proposed fully implementing a new risk-adjustment model. After many groups, including MedPAC, raised concerns that it artificially lowered payments and affected plans serving a large share of chronically ill beneficiaries, CMS opted to phase-in the new model by blending it with the previous model.

While I understand you cannot comment on the specifics of upcoming notices, are these types of trends informing CMS's rulemaking process?

Answer. We believe that the new risk adjustment model pays more accurately and supports a stronger, more robust Medicare Advantage program. The new model incorporates updates that better predict costs and improvements that will allow CMS to incorporate new diagnosis codes. In addition, the new model decreases the impact on risk scores of plans' coding efforts. CMS has used the new model for part of MA plans payments for 2014 and 2015 and expects that plans should now be familiar with the new model.

Question. As many on the Committee have discussed already and in keeping with your budget priorities and the move away from fee-for-service models, I just wanted to take a minute to highlight some of the work Colorado has been doing since the passage of the Affordable Care Act to transform the delivery system. We were one of the first states to invest in a multi-payer medical home, which resulted in a 15 percent reduction in ER visits, and significant cost savings for Coloradans in both public and private plans. This model has now become the standard for primary care across the state. Similarly, our Medicaid program launched an Accountable Care Collaborative that links every member to a primary care provider to coordinate his or her care. This program saved $44 million in our state over the last three years and resulted in a nearly a 20% reduction in hospital readmissions.

As we begin to see more of these results from successful state models, what are your plans for scaling these efforts?

Answer. We applaud Colorado's achievements to transform their health care system to improve care while also reducing cost. The Centers for Medicare and Medicaid Services is actively working with states, consumers and health care providers to transform the health care delivery system. Through the CMS Innovation Center, we are supporting the development and testing of innovative payment and service delivery models that aim to achieve better care, better health, and lower cost through improvement for our health care system. Also, as you may know, last year CMS launched the Medicaid Innovation Accelerator Program (IAP) to accelerate new payment and service delivery reforms in the Medicaid program. We are using the IAP to work closely with states, consumers, and health providers on these critical issues through technical assistance, tools development and cross-state and national learning opportunities.

And how can we here in Congress help HHS as it begins the process of taking these state models nationwide?

Answer. Initiatives such as the IAP, Health Homes, and demonstration waivers serve as avenues by which states can test delivery system models and collaborate in an environment that produces real results. Through the IAP, we are building on lessons and recommendations we have heard from our state partners for specific opportunities to advance innovation, and we will develop strategically targeted resources and technical assistance that states can leverage to accelerate Medicaid-focused innovations to transform health care. Efforts to expand successful models will take place after the evaluation of these models.

QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON

Question. Last May, I, along with Chairman Hatch, HELP Committee Chairman Alexander, and Senator Burr sent a letter to FDA Commissioner Hamburg raising a number of serious concerns about the FDA's use of draft guidances. We have still not received a response. Additionally, it took 10 months for the FDA to respond to questions for the record from a Senate HELP Committee hearing last March. As the Senate prepares to consider reforms to strengthen America's leadership in medical innovation, we are going to need much more cooperation and responsiveness from HHS agencies, including the FDA.

Will you commit to ensure that we get this cooperation?

Answer. I absolutely commit to cooperating with the HELP Committee as you embark on medical innovation legislation. I understand that senior officials from the FDA, NIH, the Office of the Assistant Secretary for Planning and Evaluation, and the Office of the National Coordinator have conducted a series of briefings for the Committee staff on the innovations in medical research, streamlining medical product approvals at the FDA, utilization of "big data" and other topics. We look forward to continued discussion as the process moves forward.

Question. The President's FY 2016 budget creates the Effective Health Insurance Initiative, which spends $30 million each year for ten years for a new project to examine how changes in health insurance benefit packages impact health care utilization, costs, and outcomes.

Can you detail what specific metrics you will use to examine utilization, costs, and outcomes, as well as what you hope these results will accomplish?

Answer. The goal of the Effective Health Insurance Initiative is to produce rigorous evidence about how the structure of health insurance can be modernized in a way that improves health outcomes while controlling costs. The study's results will become a resource for policymakers and insurers to understand how changes in health insurance would affect health care quality, health outcomes, utilization, and costs.

The results of the study are intended to accomplish three key goals:

- Identify insurance designs that promote better health and lower costs by helping people become more effective health care consumers;
- Enable federal and state policymakers, employers, and insurers to select effective benefit designs and evaluate costs of alternative designs, including for key populations of interest; and
- Provide sound data to estimate how changes in health insurance may impact spending growth.

Metrics to examine utilization include the share of people who use any health care services and the number of services used, measured overall and by specific categories such as inpatient hospital, outpatient hospital, physician, pharmaceutical, and across preventive, chronic, and acute care. Examples of cost metrics include total spending per person; spending by service type; and the number of episodes and costs per episode of spending. Quality and health outcomes metrics will draw from an array of recently developed measures including receipt of clinically recommended care, preventable hospitalization rates, outcomes following episodes such as hospitalizations, consumer assessments of health plans and health care, and patient health and functional status. Further, this study will provide an opportunity to examine these metrics among subpopulations, such as those with chronic illness or low-incomes, where targeted findings could provide particular improvements.

Question. How will the fate of this study differ from the 21-year National Children's Study which abruptly ended in December of 2014 yet cost approximately $195 million for each year of its existence?

Answer. The Effective Health Insurance Initiative will build upon the successful experience of a prior large scale study whose results are still used today. In contrast, the National Children's Study (NCS) was a proposed national longitudinal study of environmental influences (including physical, chemical, biological, and psychosocial) on child health and development—a first of its kind undertaking. The National Academy of Sciences conducted two reviews of the NCS, with a similar conclusion in 2014 as in 2008, ". . . [the study] offers enormous potential, but it also presents a large number of conceptual, methodological, and administrative challenges." As a result of a review by an Advisory Committee to the NIH Director (ACD) working group, which determined that the NCS was not feasible as currently outlined, the NIH Director discontinued the study. However, NIH remains committed to research at the intersection of environmental and children's health, and will support research in this area through alternative approaches.

The aim of the Effective Health Insurance Initiative is to foster judicious use of health care resources. To do so, the Effective Health Insurance Initiative will build upon the proven success of the landmark 1970 Health Insurance Experiment study, and leverage recent research advances. Not only was the Health Insurance Experiment successfully completed, its results are still regarded as the best evidence on the effects of cost sharing on utilization and outcomes due its gold standard random-

ized study design. The Effective Health Insurance Initiative will utilize a strong infrastructure of already developed conceptual underpinnings, metrics, and data collection techniques that have been refined over the past four decades. In addition, it will develop a management and scientific oversight infrastructure to ensure sound study design and operations. In sum, the Effective Health Insurance Initiative is a feasible and valuable study whose results would facilitate effective health care resource use in the years ahead.

Question. Several weeks ago, your department announced a target of tying 50 percent of Medicare payments to alternative, value-based payment models by 2018. That's an admirable goal, but I think it's worth noting that 30 percent of Medicare beneficiaries are already enrolled in Medicare Advantage plans that receive capitated payments. I'm concerned that CMS policies continue to discourage plans from signing up seniors with multiple chronic conditions who would benefit the most from care coordination. The Medicare Payment Advisory Commission has estimated that Medicare's risk adjustment model already underpays by 29 percent for the sickest beneficiaries, yet your budget proposes $36 billion in additional cuts to Medicare Advantage risk adjustment.

Why has CMS continued to offer further cuts while ignoring the proposals from MedPAC and others to improve risk adjustment, such as paying more to care for beneficiaries based on the number of chronic conditions they have?

Answer. The purpose of risk adjustment is to target payments to those plans that have relatively sicker enrollees and, therefore, higher expected costs. We believe the new model incorporates updates that improve payment accuracy while at the same time addressing differential coding patterns by some Medicare Advantage Organizations. Model updates are not intended to cut payments to Medicare Advantage plans, but to pay more accurately. CMS takes seriously suggestions for model improvement from stakeholders and continuously conducts research to explore the best approach to improving the model.

CMS appreciates the importance of identifying ways to better align incentives and improve care for beneficiaries with chronic conditions. CMS is working through a variety of programs and demonstrations to test models of care and the effectiveness of coordinated care for high-risk beneficiaries. Models such as the Comprehensive Primary Care (CPC) Initiative and the Pioneer Accountable Care Organization (ACO) Model are structured in such a way that many practices and awardees have chosen to focus on the chronically ill as a means by which to achieve savings and show success in the program. In addition, the Center for Medicare and Medicaid Innovation is working on developing new payment and delivery models specifically focused on innovation in health plans. Public responses to a request for information issued in late 2014 generated valuable feedback to inform this work. Such payment and delivery models will further move Medicare towards value-based purchasing.

Question. Hundreds of trauma centers have closed over the past two decades providing diminished access in particular for rural communities and in areas with high shares of African-American residents, low-income people, and the uninsured. We have seen this impact in Georgia as trauma center closures continue to exacerbate disparities in access and quality of health coverage in our state and across the nation.

Why has the Administration not prioritized trauma and emergency care funding in the FY2016 Budget?

Answer. I would like to assure you that federal support for local trauma systems, emergency care, and disaster preparedness remains a high priority of the administration. From 1992–2005, trauma systems grants supported through the Health Resources Services Administration (HRSA) provided $17 million to "enhance the development of trauma care systems." The Trauma system grants served as a key building block to saving the lives of injured Americans. Now, 90 percent of the U.S. population, and 89 percent of Georgians, are within 60 minutes (by ground or air) of a level 1 or 2 trauma center (2010, data, reference: www.traumamaps.org). While there are state and local challenges, the overwhelming majority of Americans now have rapid access to trauma care.

We are committed to support trauma and emergency care. ASPR supports the Emergency Care Coordination Center (ECCC) which leads the U.S. Government's efforts to create an emergency care system that is patient and community-centered, integrated into the broader healthcare system, high quality, and prepared to respond in times of public health emergencies. The ECCC convenes a government-wide Council on Emergency Medical Care (CEMC) to identify and prioritize inter-

agency emergency care issues. ECCC has brought increasing attention to emergency and trauma care in the delivery system reform initiative that is currently a key focus of the administration. Our vision is that Trauma, burn, and emergency care on the whole will be seamlessly integrated into the broader healthcare system.

Also, ASPR's Hospital Preparedness Program (HPP) supports regional emergency and disaster care system planning, along with a complementary Public Health and Emergency Preparedness Program at the Centers for Disease Control and Prevention (CDC).

HHS is also an active member of the Federal Interagency Committee on EMS (FICEMS) which coordinates federal agencies involved with state, local, tribal, and regional emergency medical services, 9–1–1 systems and trauma centers.

HHS continually encourages improvement in the delivery of health, emergency, and trauma care. We recognize that the day-to-day health care and public health system are the foundation of a community's ability to respond and recover from disasters and these systems must function effectively. Because the private sector encompasses most emergency and trauma care enterprises, HHS sponsors, through ASPR and CDC preparedness grants, research, guidance, and support to emergency and trauma care systems. I look forward to working with you to ensure we support the important work of our nation's dedicated trauma centers.

I would like to assure you that federal support for trauma systems, disasters, and emergency care remains a high priority of the administration.

Question. In June of 2014, the Department of Health and Human Services (HHS) announced a delay in the release of the Final Rule on Medicaid Covered Outpatient Drugs. What is HHS' current timeline for release of the Final Rule, Final AMP-based Federal Upper Limits (FULs) and corresponding guidance for implementation of the Final AMP-based FULs?

Answer. As you know, on February 2, 2012 the Centers for Medicare & Medicaid Services (CMS) issued a notice of proposed rulemaking (NPRM) on Medicaid covered outpatient drugs. This proposed rule would revise requirements pertaining to Medicaid reimbursement for covered outpatient drugs to implement provisions of the Affordable Care Act. This proposed rule would also revise other requirements related to covered outpatient drugs, including key aspects of Medicaid coverage, payment, and the Drug Rebate Program.

The NPRM generated significant feedback from stakeholders. We are continuing to work on the Medicaid Covered Outpatient Drug final rule (CMS–2345–F), but, at this time, do not have a release date. As stated in a November 2014 Informational Bulletin, CMS expects to release the Affordable Care Act Federal Upper Limits (FULs) at or about the same time that we publish the Medicaid Covered Outpatient Drug final rule. At that time, we also plan to issue formal detailed guidance to the states on implementing the Affordable Care Act FULs.

Question. Once HHS releases the Final Rule on Medicaid Covered Outpatient Drugs, the Final AMP-based FULs and corresponding guidance, the states will need time to implement those changes. State efforts may prove difficult due to the timing of state legislative sessions, the need for cost of dispensing studies, and the legislative and regulatory process for changing Medicaid drug reimbursement methodologies.

In light of these concerns, will HHS provide states with the necessary one year time frame for implementation?

Answer. CMS is mindful of states' concerns in this area. CMS intends to issue formal detailed guidance to states to implement the Affordable Care Act FULs, including the information that states will need to include in their Medicaid state plan amendments and detailed timelines for compliance. We expect to release the finalized Affordable Care Act FULs and formal guidance on implementation at or about the same time that we publish the Medicaid Covered Outpatient Drug final rule.

Question. Secretary Burwell, as you know, there was an issue with some Medicare Part D drug plans listed on the Medicare Plan Finder website during the 2014 Medicare open enrollment period. Some seniors were given incorrect information regarding which pharmacies were in-network when selecting a plan last year. I appreciate CMS's efforts to work with me and local pharmacists in Kansas to establish a special enrollment period for Medicare Part D beneficiaries who enrolled in a plan that listed an incorrect pharmacy network on the Medicare Plan Finder.

How does CMS ensure that the approved plan network is accurate when presented to beneficiaries during open enrollment?

Answer. CMS appreciates that Medicare beneficiaries need accurate information on provider networks in Medicare Advantage plans. CMS' role is to ensure the plan's network meets Medicare's pharmacy network requirements, oversee the requirement that plans offer standard terms and conditions to pharmacies upon request, and monitor that the sponsor is notifying affected beneficiaries and pharmacies of major changes. Part D sponsors may add or remove pharmacies from their networks at any time during the year. Also, CMS will review its Part D plan year 2015 experience to determine what additional oversight might be appropriate to make certain that beneficiaries and pharmacies are correctly and fully informed of Part D sponsors' network pharmacy arrangements for 2016.

Question. What rules are in place to ensure beneficiaries have access to a broad network of pharmacies?

Answer. Part D sponsors must secure the participation in their pharmacy networks of a sufficient number of pharmacies that dispense drugs directly to patients (other than by mail order) to ensure convenient access to covered Part D drugs by Part D plan enrollees. CMS convenient access rules require Part D sponsors to establish pharmacy networks in which:

- In urban areas, at least 90 percent of Medicare beneficiaries in the Part D sponsor's service area, on average, live within 2 miles of a retail pharmacy participating in the sponsor's network;
- In suburban areas, at least 90 percent of Medicare beneficiaries in the Part D sponsor's service areas, on average, live within 5 miles of a retail pharmacy participating in the sponsor's network; and
- In rural areas, at least 70 percent of Medicare beneficiaries in the Part D sponsor's service area, on average, live within 15 miles of a retail pharmacy participating in the sponsor's network.

QUESTIONS SUBMITTED BY HON. PATRICK J. TOOMEY

Question. The World Health Organization (WHO) is convening the First WHO Ministerial on Dementia on March 16 and 17 in Geneva. As you know, dementia is a progressive neurological condition that affects more than 5 million Americans and another 40 million people around the world. Globally, the costs of care are creating a significant drag on global economic activity. The US has been an historic leader in biomedical research generally and in Alzheimer's efforts specifically. It would seem to me that it would be important that our top health official attend this WHO Ministerial. What is your view?

Answer. The Department of Health and Human Services (HHS) strongly supports all work on dementia that can help accelerate our understanding of the condition and any possibilities for medical and human services interventions. HHS also understands that until interventions can be developed, work must also focus on improving the current care of patients with dementia and supporting patients and their caregivers. To this end, HHS coordinates the National Plan to Address Alzheimer's Disease and the National Advisory Council on Alzheimer's Research, Care, and Services, both mandated by the National Alzheimer's Project Act.

HHS understands that the U.S. is inextricably linked to global effects of and efforts on dementia, and that we necessarily need to collaborate with international partners to achieve the fastest outcomes and advancements possible. For this reason, from the beginning we have been and remain strong supporters of the Global Action Against Dementia (GAAD), initiated by the United Kingdom under the G–8/G–7 and now transitioning to the World Health Organization, where there will be a broader collaborative reach across the globe and more stable institutional support for the work.

The importance of this topic to HHS is the reason why we sent a high-level delegation to the WHO Ministerial, representing a blend of policy and scientific expertise needed to shepherd the transition, develop a related Call for Action, and send a signal of strong and continued U.S. Government support for GAAD. Although the Secretary will not be at the event in person, she has developed a personal statement of support to be read at the event on her behalf by the ranking U.S. diplomat to the UN in Geneva, Ambassador Pamela Hamamoto. Additionally, the Secretary will

be attending the Sixty-Eighth World Health Assembly in Geneva, May 18–26, where the topic of dementia also is likely to be discussed in an international forum.

Question. In its fall 2012 regulatory agenda, the Centers for Medicare and Medicaid Services (CMS) published that a Notice of Proposed Rulemaking to revise the Medicare Programs of All-Inclusive Care for the Elderly (PACE) regulation would be issued in July 2013. Since then, the projection has been delayed to December 2013, August 2014, and most recently to Spring 2015. In fall of last year I joined several Senators on this committee urging to use the upcoming rulemaking to enhance flexibility within the PACE program. What assurances can you offer that CMS will meet its deadlines and issue a revised regulation this spring?

Answer. We share your desire that the PACE program have the operational and regulatory flexibility necessary to serve our most vulnerable Medicare and Medicaid beneficiaries. CMS is currently performing a comprehensive review of the federal regulations governing PACE to identify potential regulatory changes to reflect the evolving needs and opportunities of the program. As CMS continues to contemplate potential regulatory changes to PACE they have implemented a number of improvements, including streamlining the application process, updating the notification requirements for the use of alternative care settings, and establishing a new PACE council to bring together different components of the agency to focus on PACE issues.

QUESTIONS SUBMITTED BY HON. MIKE CRAPO

PART D

Question. Time and again, Obamacare has proven government intervention in our health care system does not work. Hundreds of thousands of Americans have been forced from the insurance and doctors they liked because of this law. Premiums and deductibles continue to rise. Little to nothing has been done to address the underlying causes of rising health care costs—instead this Administration has relied on the ill-conceived notion that government bureaucracy is the answer to the many inefficiencies plaguing our health care system. Your budget now requests the authority to micro-manage Medicare Part D, a market-oriented prescription drug program chosen by 35 million Medicare beneficiaries, which has proven to be successful because the government has been prevented from interfering.

Why has the Administration not yet learned that increased government control of the market reduces choice, raises costs, and diminishes quality?

Answer. The Medicare Part D prescription drug benefit program has been very successful. The program has made medicines more available and affordable for Medicare beneficiaries, leading to improvements in access to prescription drugs, better health outcomes, and greater beneficiary satisfaction with their Medicare coverage. In addition, the drug benefit is helping beneficiaries avoid the need for other services that would otherwise be covered under Medicare Parts A and B; the Congressional Budget Office (CBO) has estimated that a one percent increase in the number of prescriptions filled by beneficiaries causes Medicare's overall spending on medical services to fall by roughly one-fifth of one percent. According to surveys, 95 percent of Part D enrollees are satisfied with their drug coverage and confident that the level of coverage meets their needs.

While beneficiaries are saving money, government subsidies for reinsurance and low-income cost sharing subsidies continue to increase. Moreover, Part D costs are projected to increase with the introduction of new, expensive biologic therapies, making it important to find ways to reduce costs when possible in order to keep premiums low.

Question. Would you be willing to work with Congress to choose a smarter path that increases competition and brings down costs to beneficiaries?

Answer. HHS is always willing to work with Congress to improve the Medicare program, including the Medicare prescription drug benefit.

MEDICARE ADVANTAGE

Question. Your budget again proposes cuts to the successful, market-based Medicare Advantage (MA) program. CMS's repeated attempts to use the MA program as a "piggy-bank" to offset Medicare program inefficiencies undermines the future stability of the program. Furthermore, CMS continues to phase-in a flawed risk adjust-

ment (RA) model that has been called inaccurate by MedPAC. The proposal also ignores the practical experience and knowledge of providers that understand the implication of such actions on beneficiaries.

Shouldn't the risk adjustment model ensure plans have appropriate resources to deliver high-quality care and services to beneficiaries and reflect improvements recommended by MedPAC and other stakeholders?

Answer. The purpose of risk adjustment is to target payments to those plans that have relatively sicker enrollees and, therefore, higher expected costs. We believe the new model incorporates updates that improve payment accuracy while at the same time addressing differential coding patterns by some Medicare Advantage Organizations.

Question. How can CMS better incorporate the recommendations of stakeholders and others in the development of an improved risk adjustment model?

Answer. CMS takes seriously suggestions for model improvement from stakeholders and continuously conducts research to explore the best approach to improving the model.

Question. What can CMS do to ensure transparency when making adjustments to the RA model?

Answer. Whenever CMS updates a risk adjustment model they provide a description of the updates in the Advance Notice for the relevant payment year. They often provide information for review outside the Notice process, including updated diagnoses groupings and plan-specific impacts. CMS will continue this practice, as well as explore ways to share information prior to the Advance Notice. We are open to discussions with stakeholders on how we can better communicate information about models updates.

Question. I note your interest in health care delivery reform and moving to coordinate care for Medicare beneficiaries. Fortunately, in Medicare Advantage, we have a program in place that already does that cost-effectively and successfully. In many rural states, such as Idaho, Medicare Advantage plans have used collaborative efforts to increase beneficiaries' primary care visits by almost 100 percent.

The key to reducing cost in the Medicare program is coordinating patient care, especially for those that have many chronic conditions. Getting these patients to see a Primary Care Physician (PCP) is critically important because research shows most beneficiaries with chronic conditions won't participate in a chronic care program without the encouragement from a PCP.

These seniors are getting their care directed and coordinated, and this is precisely the kind of results we want to encourage. Many are concerned, however, that, as you look at payment rates for 2016, the MA program is going to be cut or curtailed in its ability to provide the best possible care for our seniors in Idaho and around the country.

What should we expect as we look forward to the next MA rate notice?

Answer. Enrollment in Medicare Advantage plans is now at an all-time high and quality in the Medicare Advantage and the Part D Prescription Drug Program continues to improve. Medicare Advantage has reached record high enrollment each year since 2010, a trend continuing in 2015 with a total increase of more than 40 percent since passage of the Affordable Care Act, and premiums have fallen by nearly 6 percent from 2010 to 2015. And, more than 90 percent of Medicare beneficiaries have access to a $0 premium Medicare Advantage plan. CMS is focused on building on this success with policies that will enhance the stability of the Medicare Advantage program and continue the movement to reward providers of high quality, consumer-friendly care.

CRITICAL ACCESS HOSPITALS

Question. The Administration has proposed various cuts to critical access hospital (CAH) reimbursements and participation, including repealing CAH designation for facilities within 10 miles of another hospital. This distance requirement does not consider the services offered by the "other" hospital. For example, there is a CAH in Blackfoot, Idaho, within two miles of two different hospitals. However, one of these facilities is a state-owned psychiatric facility that provides long-term and acute inpatient care for mentally ill patients. The other is a small neurological specialty hospital that provides primarily spinal surgery services and does not have an emergency department staffed with a physician 24 hours a day. Under the Presi-

dent's proposal, this CAH in Blackfoot, Idaho, would lose its designation, even though the other two facilities are incapable of providing emergency capabilities or obstetrics.

What steps will you take to ensure rural residents continue to have access to health care services should CMS adopt this proposal?

Answer. We take the concerns and care of rural Americans very seriously and agree that adequate access in these areas is critically important. This proposal is targeted to ensure that hospitals that are the only source of emergency and basic inpatient care for their communities will maintain Critical Access Hospital status. Only communities that have another source of hospital care within ten miles will be affected. In addition, it is anticipated that the vast majority of these CAHs would continue to participate in Medicare as hospitals paid under the applicable prospective payment system, and would continue to provide hospital services to their communities without reliance on CAH designation. In addition, because Medicare is not the only payer for these CAHs, they could also continue receiving payment from other payers.

In the event that some of the potentially affected CAHs were to close, CMS analysis found that there likely is sufficient capacity in nearby facilities to provide the services any closed CAH had been providing. Overall, the data suggests that there would be no significant issues related to access to inpatient acute care services or skilled nursing services for the communities currently being served by the potentially affected CAHs should the CAH cease to provide services rather than convert its Medicare agreement to participate as a hospital. Additionally, HHS will continue to monitor rural communities to ensure that access to medical care is preserved.

Question. Does the President support an exceptions process for CAHs like the one in Blackfoot, which are the only facilities capable of providing emergency response and other essential procedures in their respective communities?

Answer. If this proposal became law, the impact on the status of any particular CAH would be determined by the CMS regional office on a case-by-case basis and would depend on the legislative language and implementing regulations.

QUESTIONS SUBMITTED BY HON. MICHAEL B. ENZI

MANDATORY HEALTH CARE SAVINGS

Question. The President's budget includes $400 billion in displayed net mandatory health care savings. The President also call for an extension of CHIP funding, a permanent Medicare "doc fix," an immigration plan that would increase health spending and new Medicare spending as a result of turning off the BCA sequester.

When you add these elements of the President's budget to the $400 billion in displayed net mandatory health savings, what is the new net health savings amount?

Answer. The Budget includes about $400 billion of specified net health savings that grow over time, extending the life of the Medicare Trust Fund by approximately five years, and building on the Affordable Care Act with further incentives to improve quality and control health care cost growth. This includes a proposal to accelerate physician participation in high-quality and efficient health care delivery systems by repealing the Medicare Sustainable Growth Rate formula and reforming Medicare physician payments in a manner consistent with the reforms included in recent bipartisan, bicameral legislation.

These savings are estimated against the Budget's adjusted baseline, which assumes that large reductions in Medicare physician payment rates required by law under a formula, commonly referred to as the "sustainable growth rate" (SGR), do not take place. This formula has called for reductions in physician payment rates since 2002, which the Congress has routinely over-ridden for more than a decade. Including this adjustment to baseline spending allows the Administration to better represent the deficit outlook under current policy and serves as a more appropriate benchmark for measuring policy changes.

Outside of the $400 billion in net health savings, the Budget also proposes to extend funding for the Children's Health Insurance Program (CHIP), ensuring continued, comprehensive, affordable coverage for children enrolled in CHIP. This proposal is paid for through an increase in tobacco taxes that will help reduce youth smoking and save lives.

The Budget continues to propose commonsense, comprehensive immigration reform that would strengthen border security, modernize the legal immigration system, and provide a path to earned citizenship. The Congressional Budget Office (CBO) estimates that the 2013 Senate-passed immigration bill, S. 744, would have reduced deficits by almost $1 trillion over 20 years. The Budget includes an allowance for the budget effects of immigration reform based on the CBO cost estimate.

Finally, the Budget includes $185 billion in net costs to replace mandatory sequestration government-wide. The policy estimates for the President's Budget for Medicare include the effects of the proposal to replace mandatory sequestration, along with the effects of all of the Budget's health savings proposals.

KING V. BURWELL

Question. The Supreme Court will issue a decision in the King v. Burwell case before the end of its term in late June of this year. A ruling in favor of the plaintiff could have major budgetary implications by, in effect, invalidating exchange subsidies, the employer mandate, and much of the individual mandate in up to 37 states. A recent analysis by the Urban Institute concluded that the total budgetary effect of a ruling in favor of the plaintiff could be as much as $340 billion over the 10-year budget window.

Has the administration done its own estimate of the likely budgetary impact of such a ruling?

Answer. It has not.

Question. Has the administration estimated how many *HealthCare.gov* enrollees would lose subsidies?

Answer. Individuals with a 2015 plan selection through the Marketplaces in the 34 Federally-facilitated Marketplace states who qualify for an advance premium tax credit would lose subsidies.

Question. Similarly, has the administration estimated how many individuals and employers would then be exempt from penalties under the individual and employer mandates?

Answer. As noted in the Government's brief in King v. Burwell, if tax credits were no longer available in States with federally-facilitated Exchanges, millions of people currently relying on them to pay for insurance would be exempt from the individual-coverage provision because they would not be able to afford insurance.

Question. In light of the significant budgetary implications, has the Administration been working on any contingency plans in the event that the court rules in favor of the plaintiff?

Answer. We know of no administrative actions that would undo the massive damage to our health care system that would be caused by an adverse decision and, therefore, we have no plans that would undo the massive damage.

MEDICARE PART D

Question. Medicare Part D is performing well beyond expectations and its costs are coming in far below projections. Part of that success is driven by the structure in the law that restricts HHS from interjecting itself into pricing and plan structure. There are a number of policies in the president's budget that would destabilize the program, including negotiated drug pricing and expanding Medicaid-style rebates. The Congressional Budget Office (CBO) has said that, if Medicare Part D instituted drug rebates rebating similar to that in Medicaid, a substantial amount of any of the assumed savings would be lost within 15–20 years as the market adjusted over time.

Is that consistent with the agency's estimates?

Answer. The CMS Office of the Actuary provided the Department's estimate of potential savings from the proposal, "Align Medicare Dug Payment Policies with Medicaid Policies for Low-Income Beneficiaries." The actuaries project that this proposal would reduce future Medicare spending by $116.1 billion over 10 years (Fiscal Year 2016 through Fiscal Year 2025). The actuaries have not provided estimates of any of the President's Budget proposals beyond the 10-year budget window.

Question. Does the Secretary agree that, as CBO has repeatedly cautioned, there is a risk that it these proposals will also reduce innovation and depress investment by drug manufacturers in research and development?

Answer. Analysis has found substantial differences in rebate amounts and prices paid for brand name drugs under the two programs, with Medicare receiving significantly smaller rebates, resulting in Medicare paying higher prices than Medicaid. Prior to the establishment of Medicare Part D, manufacturers paid Medicaid rebates for drugs provided to dual eligible individuals, who were subsequently enrolled in Part D for their prescription drug coverage.

Manufacturers have sufficient incentives—the desire to have their products covered on a preferred tier—to offer price concessions to Part D plan sponsors. Competition within a specific drug class from other brand or generic options will also play an important role in keeping down the cost of drug coverage.

EXCHANGE GRANTS

Question. Under the ACA, each exchange is expected to be self-sustaining beginning January 1, 2015. Please describe the "Affordable Exchange Grants" for which $380 million has been requested in the president's budget.

Please describe how these grants would differ from Early Innovator, Planning, or either category of Development Grants, the last of which were awarded in 2014.

Answer. The $380 million in the President's Budget for Affordable Exchange Grants represents outlays of previously awarded grants and does not support any new grant awards. The final round of grant funding was awarded in December 2014, but states may continue to spend their funding on establishment-related activities for one year following the date of award. States may request No Cost Extensions to extend the project period beyond one-year from the date of the initial award.

CMS used a phased approach to provide resources to states based on their progress and the approach that worked for their state. This included planning grants in 2010, which provided states up to $1 million to plan the early phases of establishing an Exchange in their state that would work best for their citizens; early innovator grants in 2011, which provided a small number of states resources to begin the IT build of their exchange; and establishment grants in 2011-2014, which provided states resources to establish a State-based Marketplace, to build functions that a state elects to operate under a State Partnership Marketplace, and to support state activities to build interfaces with a Federally-facilitated Marketplace.

CO–OPS

Question. In light of the collapse of one CO–OP in Iowa, the largest CO–OP in the country, and concerns about instability in other markets, please describe the estimates that HHS makes regarding the loan program as relates to the ability of those plans to repay and detail steps being taken by HHS to promote repayment of the $2.5 billion in loans awarded through this program.

Answer. Implementation of the CO–OP program has been a collaborative effort among CMS, state Departments of Insurance (DOIs), and the new CO–OP plans. States are the primary regulator of health insurance issuers and market rules and state DOIs oversee the financial stability of issuers and protect consumers in those markets. In addition to state regulation, CMS's role is to monitor CO–OPs for compliance with their loan agreements and program policies.

CMS continues to conduct oversight of CO–OPs as they enter their operational phase. CO–OP account managers have regular status meetings during which CO–OPs report on progress in achieving milestones, as well as about progress on operational experience. To ensure strong financial management, CO–OPs are required to submit quarterly financial statements, including cash flow data, receive site visits by CMS staff, and undergo annual external audits, in order to promote sustainability and capacity to repay loans. This monitoring is concurrent with ongoing financial and operational monitoring by state insurance regulators.

Question. Please describe any interactions that HHS had with CoOportunity in Iowa leading up to the determination by the State Insurance Commissioner that they be liquidated.

Answer. In late December, the state of Iowa brought to our attention their immediate concerns over the rapidly deteriorating financial viability of the CoOportunity insurance company. CMS has worked with the Iowa Department of Insurance and the CoOportunity to assist with the smoothest possible transition for the current members of CoOportunity.

Question. What involvement will HHS have, if any, in the process of dissolving the entity?

Answer. On December 23, 2014, the Iowa Insurance Division concluded that CoOportunity did not have sufficient funding to remain viable and placed CoOportunity in rehabilitation. During this time, the Iowa Insurance Division determined that rehabilitation was not possible and announced on January 23, 2015, that it would seek a liquidation order for CoOportunity Health for February 28, 2015. As a result, CMS announced that CoOportunity would be decertified as a Qualified Health Plan (QHP), effective February 28, 2015. Additionally, given CoOportunity's insolvency, the CO–OP is in violation of the Loan Agreement under Section 15.2(d). As such, CMS will exercise the right, under Section 16.3, to terminate the Loan Agreement with the CO–OP.

QUESTIONS SUBMITTED BY HON. RICHARD BURR

Question. Insurers signed an agreement with CMS as part of their participation in the federally-facilitated exchanges that essentially allows for the termination of such agreement in the event that tax credits or cost-sharing reductions are no longer available.

How does this provision fit into HHS's overall contingency plans if the Supreme Court strikes down the subsidies in the states that did not establish an exchange?

Answer. It doesn't. As we have previously said, we know of no administrative actions that could, and therefore we have no plans that would, undo the massive damage to our health care system that would be caused by an adverse decision.

Question. How is HHS ensuring that beneficiaries who could be impacted by such an outcome are aware that they could lose their exchange-coverage and subsidies? If no such outreach or communication has occurred to date with these enrollees, why is that the case considering the significant impact such an outcome could have for these individuals?

Answer. We don't believe that such assurances are appropriate under the circumstances. As we have previously stated, we are confident that we will prevail because the text and structure of the Affordable Care Act demonstrates that citizens in every state are entitled to tax credits, regardless of whether they purchased their insurance on a federal or state marketplace.

Question. HHS recently announced a pretty aggressive timeline for tying traditional fee-for-service Medicare payments to selected alternative payment models.

Were providers consulted on this proposal, specifically the proposed timelines for implementation?

Answer. Yes, we sought the input of providers as we developed the proposal. A number of providers were supportive of and attended the announcement of alternative payment model goals in January, including the American Academy of Family Physicians, the American Medical Association, the American Hospital Association, Trinity Health, Dartmouth-Hitchcock, Ascension Health, and Montefiore Health System.

In setting goals and timelines, HHS wanted to be ambitious while also being realistic. Almost no Medicare fee-for-service payments were paid through alternative payment models (APMs) in 2011. This percentage increased to approximately 20 percent by the end of 2014 with a goal of 30 percent of payments in APMs by 2016 and 50 percent by 2018.

Question. How will your agency decide which alternative payment models to utilize for Medicare payments? Please describe in detail.

Answer. CMS is testing alternative payment models that show promise for increasing quality and reducing costs, and CMS will scale up and continue to implement those that have a proven track record for doing so. Alternative payment models currently being implemented include the Medicare Shared Savings Program, which is operating within the standard Medicare fee-for-service payment system and was created by Section 3022 of the Patient Protection and Affordable Care Act. Various accountable care organization (ACO) models are also being tested at the CMS Innovation Center. These include the Pioneer ACO Model, which increases the level of financial risk and reward for provider organizations.

Three other types of models being tested include bundled payments, advanced primary care medical homes, and models that support states with implementing comprehensive delivery system reforms. Each of these ideas had previously been tested in the public or private sector on a smaller scale. The CMS Innovation Center is currently testing these ideas on a larger scale with rigorous evaluation criteria.

Question. Earlier this month, Chairman Alexander and I released a report analyzing the current state of medical product discovery and development. Our report, "Innovation for Healthier Americans" asks a simple, but critical, question of how we could do it better when it comes to ensuring that America's patients have access to medical products in as timely a manner as possible. The size and scope of FDA as an organization has never been more complex. As the President's budget notes, the FDA workforce has doubled since 2008.

What opportunities do you see from a management perspective to help FDA function even better on behalf of patients that don't involve further growing the Agency in terms of its size and resources?

Answer. Patients are at the core of FDA's mission and the focus of the agency's vision. Patients who live with a disease have a direct stake in the outcome of the review process and are in a unique position to contribute input that can inform FDA's benefit-risk considerations that can occur throughout the medical product development process. That is why FDA relies on patient input to evaluate and approve products.

For example, patient representatives serve on FDA advisory committees. Additionally, FDA has already held 11 Patient Focused Drug Development meetings to learn more about the patient experience, as required by the Food and Drug Administration Safety and Innovation Act of 2012 (FDASIA). Another five are planned in 2015 and more will take place in 2016 and 2017.

FDA's research on patient tolerance for risk helped inform the recent clearance of an implantable obesity device. FDA is currently developing other tools to better measure patient preferences and tolerance for risk including a benefit-risk assessment for new drugs and biologics.

FDA is constantly involved in management changes and innovations within the agency to better serve the American people. The agreements made pursuant to the various user fee agreements are part of the roadmap for improving the agency. Other initiatives stem from major legislation enacted in recent years such as FDASIA and initiatives undertaken by the Commissioner. In addition, we have reviewed the report authored by you and Chairman Alexander and look forward to working with you as the Senate shapes legislation to increase access to innovative medical products. Our goal throughout is to emerge with an FDA that is as efficient as possible and to increase access to safe and effective medical products that benefit the American people.

Question. How can we better utilize the significant resources FDA already receives?

Answer. We believe that FDA does exercise prudent use of resources. This is partially evident by the trust that industry places in the agency year after year in the expenditure of industry user fees. One area where there is potential to better utilize existing resources is with respect to retention of medical and scientific experts. The medical product industry is concerned that many of their new therapeutic technologies will require FDA to have additional sophisticated technical and scientific expertise if FDA is to be able to efficiently and expeditiously review those new therapies for approval and conduct post-market surveillance activities. However, in many cases, these experts are able to command higher salaries in the private sector than FDA can provide. I would welcome a discussion with you on the use of funds by the FDA and to hear your suggestions on how things could be improved.

Question. The President's budget acknowledges the significant growth in appeals coming before the Office of Medicare Hearings and Appeals. I consistently hear concerns from my constituents back home about the need to make sure the audit and appeals processes are as fair and predictable as possible. What reforms do you believe would be most impactful to increase the predictability and timeliness of the audit and appeals processes?

Answer. The Department has a three-pronged approach to addressing the increasing number of Medicare appeals and the current backlog. First, invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog. Second, take administrative actions to re-

duce the backlog and to appropriately resolve claims at earlier levels of the appeals process. Third, pursue legislative proposals described in the President's FY 2016 Budget that provide additional funding and new authorities to address this urgent need.

Legislative proposals along with additional resources requested in the President's FY 2016 Budget set a framework for bringing the Medicare appeals process into balance going forward. For example, the legislative proposal to establish a refundable filing fee at each level of appeal will encourage providers to be more judicious in determining what they appeal. Providing authority to consolidate appeals requests, the authority to group similar claims together to allow for a single decision on multiple claims, will improve the efficiency and timeliness of the Medicare appeals process. Increasing the minimum amount in controversy required for adjudication by an administrative law judge to the Federal District Court amount in controversy requirement will reduce the volume of claims that could be appealed for ALJ review.

The Budget requests $270 million, an increase of $183 million above the FY 2015 level, to address the backlog of over 800,000 pending appeals at OMHA. The Budget includes $140 million in budget authority and $130 million in program level funding from proposed legislation to support new field offices and additional Administrative Law Judges teams. It will also support appeals adjudication by less costly methods such as settlement facilitation and the proposed Medicare Magistrate program. The 2016 Budget invests $36.2 million to allow CMS to engage in discussions with providers to resolve disputes earlier in the appeals process and greater CMS participation in Administrative Law Judge hearings at OMHA. This investment will improve the efficiency of the Medicare appeals process at the third and fourth levels and reduce the number of claims appealed beyond the CMS levels, enabling the OMHA to more quickly adjudicate its current backlog. The Budget also requests $12.5 million, an increase of $2.5 million above FY 2015 level, to hire additional staff to address Medicare appeals at Level IV (the Medicare Appeals Council).

QUESTIONS SUBMITTED BY HON. JOHN THUNE

EMTALA

Question. In South Dakota, several hospitals in rural areas that border Indian reservations see a high volume of emergency cases with patients who primarily receive care at Indian Health Service facilities entering their emergency departments. EMTALA requires that providers provide care for patients who present at an emergency facility. Claims by private providers for this emergency care are often denied. Providers appeal but the appeals languish at the highest level of appeal with no response. This results in no reimbursement for care they were required by federal law to provide.

If providers claims are denied at the local level, how are these appeals evaluated at the headquarters level?

Answer. Indian Health Service adheres to the appeal process set forth in 42 CFR 136.25, which establishes a three-stage, time-limited appeals process for patients and providers. The IHS Director considers appeals only after denial decisions have been made by the facility Chief Executive Officer (CEO) and the IHS Area Director. To be considered timely, the PRC appeals must be submitted in writing to the appropriate reviewer within 30 days after receipt of the notice of denial.

All appeals submitted to the IHS Director are reviewed to ensure the local and Area appeals requirements have been met. Cases are reviewed on an individual basis to ensure sufficient information is provided to make an appeal decision. Appeals are reviewed for patient eligibility, access to alternate resources, medical priority, availability of IHS facilities and PRC program notification requirements. If an appeal is denied for a medical priority, all related medical records must be obtained for a Headquarters medical review. After documentation and medical reviews are provided, all information is considered and a decision rendered regarding the appeal. All decisions are reviewed by program staff and senior leadership before the IHS Director issues the decision.

Question. In what timeframe should providers expect that claims will be reviewed?

Answer. Timeframes for review can vary depending on the case, the reason for denial and the information submitted for review. A recent factor that affects the re-

view time is the number of denials that are appealed. Some health care providers are appealing every denial decision received by the facility which has resulted in the number of appeals increasing fivefold over the last 18 months. In 2014, almost 500 denials were appealed to the IHS Headquarters.

IHS recognizes the burden that delayed responses create for patients and providers and is improving business practices to effectively address the current workload while maintaining adequate consideration for each patient and case. IHS is drafting new procedures and workplans to address the increase in appeals. Area staff have been brought to Headquarters to assist with the research and review that is required for appeals adjudication and to provide feedback on successful Area processes that Headquarters may replicate. Dual timelines are being implemented to address current appeals as well as the backlog of appeals. With increased efforts focused on PRC appeal adjudication, patients and providers can expect more timely responses from IHS Headquarters.

VA/IHS

Question. As you know, for care that cannot be provided at an IHS service unit, patients are referred out through the IHS PRC program. Patients may be referred to a private provider or in some cases to a Veterans Affairs (VA) facility. In accordance with the law, eligible Indian veterans who are referred to the VA are required to be charged a copayment for services at the VA. Under a separate federal statute, providers are not permitted to impose financial liability on a patient pursuant to an authorized PRC referral. We understand that conflicting federal statues have resulted in eligible Indian veterans being held responsible for the VA copayments. My office has been working with both the VA and IHS for the last two years to better understand and address this issue.

Is this an issue that can be resolved administratively?

Answer. Federal law prohibits providers from charging IHS patients for authorized PRC referrals. As noted above, American Indian and Alaska Native (AI/AN) Veterans have overlapping eligibility for services provided at IHS and VA facilities. When an AI/AN Veteran is seen under the authority of the IHS, there is no copayment. The AI/AN Veteran is never charged for any level of care received directly at an IHS facility.

Question. If not, what particular legislative changes are necessary to allow for PRC dollars or other IHS funds to be used to cover the cost of a required VA copayment?

Answer. Currently, IHS has no recommendations for legislative change.

Question. Are there technical barriers to implementing a process for PRC to cover eligible Indian veterans' copayments at the VA?

Answer. The issue is due to statutory authority and not related to technical barriers for IHS/PRC program.

INTERNAL POLICIES AT IHS

Question. My staff regularly works with the office of congressional affairs and previously, officials from the Great Plains office, on both constituent and legislative issues. Unfortunately, we often find that it is difficult to receive timely responses to inquiries and communicate with local IHS staff. My staff was recently prohibited from visiting an IHS facility without clearance—which took weeks to obtain—from headquarters. We also understand that service unit CEO's have been instructed not to provide even basic information to my office without prior clearance. Often, my staff is working on time sensitive issues that could be resolved quickly if information sharing at the local level was permitted.

Can you provide me with information regarding internal policies specific to communication with individual service units and the area office and Congressional offices, including the rationale for these policies?

Answer. I am sorry that your staff has had difficulty. Congressional requests for site visits, field hearings, etc., should be made through IHS headquarters legislative staff who customarily work with health staff on scheduling appropriate dates and times for staff and member visits and to ensure appropriate area office and/or service unit leadership are available. Additionally, we are particularly sensitive to the need to protect patient confidentiality during site visits to hospitals or health facilities, so visits are arranged in a manner that takes such concerns into consideration. If there is ever any question regarding this process, please contact IHS Head-

quarters legislative staff directly and they will ensure all requests are coordinated with appropriate personnel in the Areas and Service Units. If they are unable to assist, please contact the Office of the Assistant Secretary of Legislation at HHS.

Question. This fall, my staff organized a purchased and referred care roundtable with various stakeholders, including the IHS. My staff requested, and was promised, prior access to the information that would be presented by the IHS. After numerous requests, the information was provided after close of business the night before the event, leaving my staff without time to evaluate the information. These are just a few examples of what has become a pattern of untimely responses to requests from the IHS headquarters office. Another example is the response to a letter I sent that arrived eleven months after I sent my letter. This is unacceptable.

While I certainly recognize that the headquarters office is responding to a multitude of requests, I am interested in hearing how you are working to improve response times and what goals the IHS has for average response times?

Can you provide me with information on the clearance process and who is required to sign off on information provided to my office?

Answer. I understand your concern. I want to assure you that I am personally committed to responding quickly and thoughtfully to letters from Members of Congress. Since I was confirmed, I have made it a top priority for the Department to respond as promptly and thoroughly as we possibly can to every letter—and I have communicated this to leadership throughout the Department.

IHS is working to improve response times by setting deadlines that allow time for review and signature, incorporate compliance with correspondence deadlines into performance plans, and focus additional staff resources to address backlogs in correspondence. The IHS goal is to respond to correspondence within a 30-day timeframe, unless issues involve other agencies' input requiring multiple levels of review outside of the agency's control. As Secretary, I am insisting that all parts of HHS improve their response time to congressional correspondence.

MEDICARE SOLVENCY

Question. It is no secret that Medicare Hospital Insurance Trust Fund will become insolvent by 2030. What is being done to help address looming insolvency of Medicare?

Answer. In 2009, the Trustees projected the Hospital Insurance Trust Fund would become insolvent in 2017. As of the 2014 Trustees Report, the Trustees project the Hospital Insurance Trust Fund will be solvent until 2030, 13 years later than the 2009 projection—an improvement that is thanks in part to cost controls implemented in the Affordable Care Act. These include reforms that are reducing excessive payments to private insurers and health care providers in Medicare, creating strong incentives for hospitals to reduce readmission rates, and starting to change health care payment structures from volume to value.

RURAL HEALTH REGULATORY BURDENS

Question. During your confirmation hearing, I asked you about what you would do to help address unnecessary regulatory burdens on rural health providers. You said, "I look forward to working with you and your colleagues to ensure that the burdens faced by rural providers are limited. By eliminating stumbling blocks and red tape we can assure that the health care that reaches patients is more timely, that it's the right treatment for the right patient, and greater efficiency improves patient care across the board."

Since you were confirmed, what have you done to follow through on this promise?

Answer. As we discussed at my confirmation hearing and in subsequent conversations we are committed to working with all providers, but especially rural providers to make sure they are able to provide their patients with the care they need when they need it. Since I arrived at HHS, we have expanded the use of telemedicine in Medicare and announced the creation of a new initiative to support care coordination nationwide, while continuing to listen to rural stakeholders.

One area that I would highlight is the area of telemedicine, which is of particular importance to rural providers and their patients. As you know, the Medicare program provides telehealth services for Medicare beneficiaries for a limited number of Part B (outpatient) services furnished through a telecommunications system by a physician or practitioner to an eligible telehealth individual, where the physician or practitioner providing the service is not at the same location as the beneficiary.

CMS considers requests to add new services annually through the physician fee schedule rulemaking process, and has established criteria for adding telehealth services. Services can be added if they are similar to existing telehealth services, or can demonstrate clinical benefits to a patient if delivered by a telecommunications system in place of a face-to-face visit. For example, CMS finalized adding psychoanalysis, family psychotherapy, annual wellness visits, and prolonged evaluation and management services as telehealth services in 2015.

The Medicare Shared Savings Program statute encourages accountable care organizations (ACOs) to coordinate care through the use of telehealth, remote patient monitoring, and other such enabling technologies. ACOs participating in the Shared Savings Program and the Pioneer ACO Model are encouraged to use these technologies. CMS also announced the creation of the ACO Investment Model, which is an initiative designed for organizations participating as ACOs in the Medicare Shared Savings Program (Shared Savings Program). The ACO Investment Model is a new model of pre-paid shared savings that builds on the experience with the Advance Payment Model to encourage new ACOs to form in rural and underserved areas and current Medicare Shared Savings Program ACOs to transition to arrangements with greater financial risk.

Another area pertains to outpatient therapeutic services in critical access hospitals. We are aware of the concerns expressed by some critical access hospitals regarding our direct supervision requirement for most outpatient therapeutic services, meaning that a physician or qualified non-physician practitioner must be immediately available during the service. Working with the Federal Office of Rural Health Policy, located within the Health Resources and Services Administration, we established the Hospital Outpatient Payment Panel to consider requests to establish alternative supervision requirements for specific outpatient therapeutic services. The Panel has been evaluating requests for changes in supervision levels for various outpatient therapeutic services.

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. The budget includes savings of $69 million over the next decade, attributed to promoting "family-based foster care for children with behavioral and mental health needs." Can you elaborate on this proposal? How will the Administration encourage family-based care for these children, many of whom have traditionally been sent to congregate care?

Answer. Children are best served when raised in safe, loving families; congregate care may be appropriate as a temporary placement for children to address complex physical, mental and behavioral health needs. This proposal is estimated to cost $78 million in FY 2016 and reduce costs of title IV–E foster care by $69 million over ten years. The Administration's cost estimate assumes that the proposal will increase the availability of family-based care and, as a result of establishing and enhancing those services, states will move children from congregate placements to family settings to better meet the needs of children while reducing the costs for IV–E.

Through this proposal, title IV–E agencies will be reimbursed with 50 percent federal financial participation (FFP) for administrative activities associated with this oversight and eligibility documentation components of the proposal. This rate is the same as current law, but we estimate that IV–E agencies will have higher claims for eligibility determination activities to implement and comply with the new requirements for documenting the justification for congregate care settings and acquiring judicial determinations every six months. We assume that the additional claims related to this new procedure will decline as the congregate care placements decline following the implementation of the supports for family-based care.

The Children's Bureau, within the Administration for Children and Families, has produced a data brief that examine how, when, and for whom congregate care is being used in the child welfare system (*http://www.acf.hhs.gov/programs/cb/resource/congregate-care-brief*). The brief highlights that seventy percent of children and youth in congregate care are age 13 and older. Most of the youth in congregate care had a DSM diagnosis, physical disability or entered care due to a child behavior problem. Some of these children and youth were initially placed into congregate care for treatment; others were subsequently placed in congregate care because they were not able to remain in a traditional foster family care placement.

The proposal seeks to reduce use of congregate care while improving outcomes for children in two ways. First, the proposal promotes family-based care for children who have been traditionally been placed in congregate care due to youth's complex needs through increased investments in alternative interventions, specialized caseworker and foster parent training, foster parent reimbursement for those providing specialized care to high-need children, and day treatment programs.

In addition, the proposal promotes family-based care, through increased oversight, for those children in congregate care, including those who have no apparent clinical indicators. In 2013, there were 15,000 children (29 percent) who were placed in a congregate care setting but had no identifiable clinical indicators.

Second, the proposal creates a new eligibility requirement under title IV–E requiring documentation to justify congregate care as the correct foster care placement setting, based on the child's mental, behavioral or physical health needs and the congregate care provider's ability to address those needs. The oversight requirements will both require more careful scrutiny of the appropriateness of these placements and give states a financial incentive to ensure that residential care placements are used appropriately and only for as long as the specific interventions provided in the placement are necessary. This proposal would require states to review the case plans for all children currently in congregate care, and new children entering congregate care setting. The goal is that children are only placed in congregate care when it is medically appropriate, and determined to be the least restrictive foster care placement setting. In order to support family based care for children with complex needs, the President's budget proposal increases reimbursement for specialized caseworker training and case management, increases reimbursement for foster parent parents who provide therapeutic care and provides additional reimbursement for day treatment.

Question. As you know, I was disappointed that you once again included deep cuts to the Children's Hospital Graduate Medical Education (CHGME) program in your FY 2016 budget. CHGME has been a major success and has enjoyed broad bipartisan support. Indeed, just last year it was reauthorized at $300 million a year for five years, which the President signed. Now he proposes funding it at just a third of that. This cut in funding puts at risk the gains that have been made for children's health under CHGME. The small class of hospitals that receive CHGME, less than one percent of all hospitals, train nearly half (49%) of all pediatricians, including 45 percent of general pediatricians and 51 percent of pediatric specialists. I know you excuse these cuts by pointing to new investments in primary and preventive care that Children's Hospitals can access, but that's not what these hospitals need most. As you know, there are serious national shortages in many pediatric specialties, shortages which the CHGME program has been crucial in helping to address. In some specialties, like pediatric rehabilitation, the CHMGE hospitals train virtually 100% of those providers. Have you considered the likely impact on specialty care from this reduced funding? Please explain how with this level of funding we can adequately ensure resources are available to train the specialty pediatric workforce of tomorrow? Very simply: who will treat our kids if we do not invest in CHGME?

Answer. I share your view that it is important to support funding for medical residency training programs for pediatric and pediatric subspecialty residents. I remain committed to working with Congress to make sure our training hospitals have the resources they need to develop a strong pediatric workforce.

The goal of our Budget proposals is to improve access to health care services for all Americans, including our nation's children. Our graduate medical education proposals target the investments where they are needed most—in primary care (including pediatrics) and certain specialties—and for practice in rural and other underserved areas.

As you noted, the President's FY 2016 Budget Request includes $100 million for the CHGME program. This request for the CHGME program supports direct medical education expenses for graduate medical education at children's hospitals. The Budget will support approximately the same number of pediatric resident slots as in previous years by funding the direct costs associated with training residents. Direct medical education spending includes stipends and salaries for residents and supervising faculty, costs associated with providing the GME training program, and overhead costs.

Another way the President's FY 2016 Budget seeks to maximize federal resources is by encouraging innovation in graduate medical education training models and

greater accountability in the use of graduate medical education funding. The President's FY 2016 Budget proposes the Targeted Support for Graduate Medical Education (TSGME) program. The TSGME proposal requests $400 million in FY 2016 and $5.25 billion over a 10-year period through a mandatory funding mechanism which would provide increased stability for the program while supporting approximately 13,000 residents.

As you are aware, children's hospitals would be eligible to receive CHGME funds and compete for the TSGME funds. The TSGME proposal would also re-orient training to community-based, ambulatory care settings. Many institutions, including children's hospitals, are already providing care using this type of delivery. As eligible entities for both the CHGME and TSGME programs, children's hospitals will have the opportunity to compete for even more funding than the FY 2015-enacted level of $265 million or FY 2016-authorized level of $300 million.

Question. I applaud the Administration's commitment to move away from a purely fee-for-service approach of providing and paying for care and toward a health system that pays for value and quality. I have advocated for and strongly believe that providers and health plans should be paid for the quality of care they deliver, not merely for the number of services they can bill and for whom coverage is provided.

However, I understand, as do you, that providers and plans that have a higher percentage of low-socio-demographic status patients face unique challenges to achieve the same health outcomes that occur in more affluent areas. Healthy food, transportation to a doctor's visit, and a warm, safe home are critical to a patient's health, yet many Americans cannot afford these basics. While I fully support delivery system reform, we must also foster policies that improve vulnerable American's health by taking on these challenges as a part of expanding accountability in medical care.

Medicare's current and new payment models that measure quality should account for the impacts on health care associated with a patient's economic circumstances. Unless our valued-based system recognizes these factors, hospitals and health plans caring for the most vulnerable patients may be unfairly penalized, and your historic effort to reward value may well fall short. Can you help me understand why this aspect was not included in your plan and how I can help you and your staff to make certain of its inclusion?

Answer. To address the issue of risk adjustment for socioeconomic status specifically, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research on this issue as directed by the IMPACT Act, and will issue a report to Congress by October 2016. This report will examine relationships between socioeconomic status and performance under CMS quality programs across a number of settings, including hospital, plan, provider, and post-acute programs, and provide insight into potential policy alternatives that might address socioeconomic status within these programs. CMS will closely examine the research conducted by ASPE.

In addition to work in quality measurement, CMS has made significant investments in the provision of technical assistance for delivery system reform efforts for providers that serve rural and vulnerable populations through our Quality Improvement Organization (QIO) program and the recently announced Transforming Clinical Practice Initiative that will assist providers in rural and underserved areas.

HHS is committed to working with you and other stakeholders to reform the delivery system while addressing any negative unintended consequences, particularly for those facilities serving dual-eligible and low-income beneficiaries. I look forward to future discussions with you and other stakeholders on ways to further improve the quality of care provided to beneficiaries.

Question. I want to raise the issue of the "Two Midnights" Rule, which is a CMS policy that was intended to try to simplify inpatient admissions by clarifying which hospital stays are reimbursable under Medicare Part A, because I am concerned that this policy has not resulted in its originally intended outcomes. This Rule utilizes time as the primary factor in qualifying a patient for a hospital stay what is reimbursable under Medicare Part A, rather than patient acuity levels and physician judgment. I know CMS has been working with stakeholders to develop a consensus on inpatient policy options. Where does that process stand? And given the current 18-month delay CMS has implemented in enforcement of this policy, can you provide me with details of what the impact of this delay is having on health outcomes and costs to the system?

Answer. After finalizing the two-midnight rule effective beginning FY 2014, CMS sought comments in the FY 2015 Inpatient Prospective Payment System (IPPS) proposed rule on an alternative payment methodology under the Medicare Program for short hospital stays. Topics for comment included the definition of short or low cost inpatient hospital stays and the determination of appropriate payment for short inpatient hospital stays. We received a number of comments indicating that any short-stay policy should adhere to certain general principles and that additional research and collaboration were needed before a formal short-stay policy proposal were to be made by CMS. CMS noted in the FY 2015 IPPS final rule that there was no consensus among commenters. Although there was no consensus, CMS stated it would take the comments into account in any potential future rulemaking to address the complex question of payment policy for short inpatient hospital stays.

CMS has undertaken extensive efforts to engage with stakeholders directly on efforts to comply with the 2-midnight rule, including numerous "Open Door Forums" and national provider calls.

In addition, CMS instructed Medicare Administrative Contractors (MACs) to conduct "probe and educate" reviews for inpatient claims with dates of admission between October 1, 2013 and March 31, 2014, to assess provider understanding and compliance with the new policy. The Protecting Access to Medicare Act of 2014 (Pub. L. 113–93) permitted CMS to continue medical review activities under the MAC probe and educate process through March 31, 2015 and precluded recovery auditors from conducting post-payment patient status reviews for inpatient claims through March 31, 2015. All MACs have completed the first round of probe reviews and provider education. Throughout the probe and educate process to date, CMS has seen positive effects and improved provider understanding of the 2-midnight rule. We believe that this process has been well-received and beneficial to the provider community.

QUESTIONS SUBMITTED BY HON. ROB PORTMAN

MEDICARE PART D

Question. Last time CMS's Administrator, Marilyn Tavenner, was before this Committee she told us that actual costs for Part D are approximately 40% less than the original estimates for the program. In addition, CBO has reduced its 10 year cost projections for Part D by over $100 billion in each of the last three years.

I believe these statements and data clearly illustrate that Part D has been a success. Yet, the President's budget targets Part D, the cost of which is ultimately borne by seniors and taxpayers. As we consider solutions to reduce the nation's debt, I encourage the Administration and my colleagues to learn from, not undermine, Part D.

Your budget proposes to give the HHS secretary—for the first time—the authority to negotiate drug prices for biologics and high-cost drugs in Medicare Part D. While I understand the growing concerns with the rapidly escalating prices of specialty and brand name drugs, I am concerned that going against the original structure of the Part D program and enabling the government to interfere in the current market structure could be detrimental to the proven success of the Part D program. Is there any concern that interfering with the existing program will undermine the market-based structure?

Answer. The pharmaceutical industry is shifting its focus from the blockbuster drugs of the 1990s to specialty pharmaceuticals. While these new treatments may represent important medical breakthroughs, their extremely high-costs raise concerns as to whether beneficiaries have access to the drugs they need. The Federal government needs to be mindful of the balance between incentivizing new pharmaceutical research with protecting the long-term sustainability of this important benefit for generations to come.

Robust competition leads to reasonable prices for many drugs in the Part D program, and that competition will remain strong under this proposal. Other major purchasers, such as health plans, employers, and pharmaceutical benefit mangers negotiate with manufacturers to get better deals for their enrollees and employees. For example, Express Scripts and CVS recently negotiated lower prices for Hepatitis C drugs. Similarly, this proposal would provide the Secretary with additional tools to leverage Medicare's buying power to obtain lower prices for high-cost and specialty medications.

The Administration looks forward to working with Congress to address growing pharmaceutical costs and this proposal is one of many potential solutions to help alleviate address the growing cost of specialty and brand name drugs.

Question. The budget also proposes to introduce Medicaid-level drug rebates to certain beneficiaries. Has HHS modeled the effect on Medicare Part D of providing Medicaid-level drug rebates to certain beneficiaries for brand name and generic drugs? Is there any concern that interfering with the existing program will undermine the market-based structure?

Answer. Analysis has found substantial differences in rebate amounts and prices paid for brand name drugs under the two programs, with Medicare receiving significantly smaller rebates, resulting in Medicare paying higher prices than Medicaid. Prior to the establishment of Medicare Part D, manufacturers paid Medicaid rebates for drugs provided to dual eligible individuals, who were subsequently enrolled in Part D for their prescription drug coverage. The rebate proposal restores the rebates that would have been made on their behalf and extends it to other low-income Medicare beneficiaries.

Manufacturers have sufficient incentives—the desire to have their products covered on a preferred tier—to continue to offer price concessions to Part D plan sponsors. Competition within a specific drug class from other brand or generic options will also play an important role in keeping down the cost of drug coverage.

Question. In early 2014, CMS released a proposed Medicare Part D rule that would have significantly undermined the success of the Part D program, a program that is relied upon by nearly 40 million seniors and individuals with disabilities. After strong opposition from a variety of health care stakeholders and from the bipartisan membership of this Committee (SFC), Administrator Tavenner sent a letter to Members of Congress stating that CMS would not move forward with finalizing the most controversial proposals, and the Agency has continued to assure Congress that it does not intend to revisit these misguided policies. Can I have your word that the Agency still does not intend to revisit these or similar Part D proposals in future rulemaking?

Answer. CMS does not plan to revisit these provisions.

COMPETITION IN FEHBP

Question. The President's Budget includes a proposal that saves a minimal amount while increasing premium for most federal workers across the United States. Ohio is particularly hard hit under the proposal. Is the Administration open to alternatives that will ensure vibrant competition in every state without having a negative impact on federal workers?

Answer. For information about the FEHBP proposals included in the President's Budget, I would refer you to Director Archuleta who would be open to discussing proposals that increase competition and reduce costs in the FEHB.

MEDICARE ADVANTAGE AND STAR RATINGS

Question. Secretary Burwell, please describe the standard that CMS holds MA plans to with respect to stars data integrity, and what are the penalties associated with even small errors in data reporting?

Answer. CMS holds plans responsible for submitting accurate data, whether the data are produced or reported directly by the plan or by a vendor under contract to that plan. The plan may receive a one-star rating for a measure if the plan's data are known to be problematic. Examples include cases where CMS finds mishandling of data, inappropriate processing, or implementation of incorrect practices by the organization/sponsor have resulted in biased or erroneous data.

Question. Now, please describe the standard that CMS holds itself to in terms of data collection to support star ratings, and the consequences associated with significant errors in such data collection?

Answer. We review on an annual basis the quality of data available for all measures, the variation among organizations and sponsors, and measures' accuracy and validity before making a final determination about inclusion of measures in the Star Ratings. This review is completed in mid-summer in preparation for the final Star Ratings, published in early October. CMS cannot publish performance ratings of plans that are based on data it cannot trust nor can we base Quality Bonus Payments to MA organizations on biased or incorrect ratings. Therefore CMS sup-

presses measures when we determine that the data collected by CMS or its contractor(s) are inaccurate.

Question. Do you mean to tell me that in either instance, it is the plan—and ultimately the beneficiary—that ultimately pays the price? That seems inequitable to me.

Answer. Suppressing a measure does not penalize plans, but rather it makes sure that we are fairly comparing all plans' performance and rewarding them accordingly. This action serves to protect, not harm, beneficiaries from using false or biased performance ratings for their enrollment choices. To use untrustworthy data would bias the Star Ratings and ultimately Quality Bonus Payments.

HHS PROPOSAL TO TIE PAYMENTS TO VALUE

Question. In January of this year, for the first time ever, HHS presented explicit goals to implement value-based payments in Medicare. According to this announcement, HHS set a goal to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. While I applaud the Administration for setting goals to move our healthcare delivery system toward a system based more on value and quality, I am curious how these goals figure into other Medicare payment issues. The budget also estimates that repealing the sustainable growth rate (SGR) and providing a zero percent update will cost $6 billion for 2015 and $131 billion between 2016 and 2025.

How does HHS's new proposal to implement value-based payments in Medicare affect the cost of repealing the SGR over the next ten years? Did you consider the cost of the SGR repeal in light of the new payment structure?

Answer. The Budget includes about $400 billion of specified net health savings that grow over time, extending the life of the Medicare Trust Fund by approximately five years, and building on the Affordable Care Act with further incentives to improve quality and control health care cost growth. This includes a proposal to accelerate physician participation in high-quality and efficient health care delivery systems by repealing the Medicare Sustainable Growth Rate formula and reforming Medicare physician payments in a manner consistent with the reforms included in recent bipartisan, bicameral legislation.

These savings are estimated against the Budget's adjusted baseline, which assumes that large reductions in Medicare physician payment rates required by law under a formula, commonly referred to as the "sustainable growth rate" (SGR), do not take place. This formula has called for reductions in physician payment rates since 2002, which the Congress has routinely over-ridden for more than a decade. Including this adjustment to baseline spending allows the Administration to better represent the deficit outlook under current policy and serves as a more appropriate benchmark for measuring policy changes.

The Budget's adjusted baseline does not include assumptions on cost changes due to HHS's new delivery system reform goals. However, going forward, HHS believes that SGR reform will strengthen our ability to reach these goals by increasingly linking payments to providers to quality and value and encouraging participation in alternative payment models.

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ

QUALIFIED HEALTH PLAN REIMBURSEMENT TO FEDERALLY QUALIFIED HEALTH CENTERS

Question. Section 1302(g) of the Affordable Care Act is a provision I authored to ensure Federally Qualified Health Centers (FQHCs) receive an adequate reimbursement for services provided to enrollees of qualified health plans through the Marketplace. This provision of law specifically states that QHPs cannot reimburse health centers an amount lower than the Medicaid PPS rate. Nowhere does this section of law provide for "mutually agreed upon" rates that are lower than the Medicaid PPS nor distinguish between in-network and out-of-network coverage.

Unfortunately, the regulations implementing Section 1302(g) have provided a number of exemptions that contradict the both the letter and intent of the law. These exemptions, on which I have had numerous conversations with HHS over the years, are resulting in serious a reimbursement shortfall for FQHCs, forcing many to use limited grant funding designed to cover uncompensated care to instead cover costs associated with QHP-enrollees.

What specific actions are CMS and CCIIO going to take to amend the current regulations, which misinterpret and misapply the statutory requirements outlined in Sec 1302(g), and ensure that *all* FQHCs receive a minimum reimbursement of the Medicaid PPS in the next plan year, irrespective of whether or not the center is in-network or out-of-network?

Answer. As you may be aware in the 2015 letter to issuers in the Federally-Facilitated Marketplaces, CMS reiterated the importance of issuers complying with federal regulations regarding payment of FQHCs. For covered services provided by an FQHC, QHP issuers must pay an amount that is not less than the amount of payment that would have been paid to the center under relevant Medicaid law for such item or service. The regulations do allow the QHP issuer and FQHC to mutually agree upon alternative payment rates, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer. CMS has encouraged issuers and FQHCs, as well as other ECPs, to develop mutually beneficial business relationships that promote effective care for medically underserved and vulnerable populations.

IMPLEMENTATION OF THE CHANGES TO THE CLINICAL LABORATORY FEE SCHEDULE INCLUDED IN THE PROTECTING ACCESS TO MEDICARE ACT OF 2014

Question. In addition to staving off a 24 percent reduction in Medicare physician reimbursements, the Protecting Access to Medicare Act (PAMA; Pub. L. 113–93) included substantial changes to the Clinical Laboratory Fee Schedule (CLFS). Among these changes are requirements that CMS collect private-market testing rates for "applicable laboratories," which the statute defines as a laboratory that derives a majority of revenue from either the CLFS, the physician fee schedule (PFS) or the section 1834A created by PAMA. CMS is further directed to use this data to reestablish laboratories' payment rates.

What level of formal stakeholder involvement, such as in-person meetings and notice and comment periods, will CMS utilize when developing the regulations for the reporting of private-market payment data? What steps will be taken (e.g. utilizing a testing period without penalties) to ensure laboratories are able to successfully comply with the reporting requirement prior to the regulations taking effect?

Answer. In July 2014, at its annual public meeting on payment for new laboratory tests, CMS added a special open session to receive stakeholder input on implementing the PAMA provisions. CMS has also listened to concerns from stakeholders during several in-person meetings about the law. CMS is currently developing a notice of proposed rulemaking to implement the PAMA provisions. As part of the rulemaking process, public comments will be invited on CMS' proposed implementation approaches, and all comments will be addressed in the subsequent final rule. In addition, PAMA required the establishment by July 1, 2015, of an Advisory Panel on Clinical Diagnostic Laboratory Tests, to advise the Secretary and CMS on laboratory payment issues including implementation of the new payment system and rates. On October 27, 2014, CMS published a Federal Register Notice announcing the establishment of the Panel and requesting nominations for individuals to serve on the Panel.

Question. Will the final definition of "applicable laboratory" include all laboratories, including independent labs, hospital outreach and outpatient labs, and labs located in a physician's office? If so, what steps will CMS take to account for the various payment systems found across these provider entities?

Answer. CMS is developing policy on each of these questions through the notice of proposed rulemaking that is currently in development. This proposed regulation will be subject to public comment before we develop a final rule to implement PAMA's provisions.

Question. When calculating the weighted median payment rate and implementing changes to payments based on that rate, how will CMS account for variations in the clinical laboratory industry, such as geographic differences, varying levels of Medicare participation or labs that specialize in serving specific types of providers such as skilled nursing facilities?

Answer. CMS will provide more information on these issues through the notice of proposed rulemaking currently under development.

HOME HEALTH FACE-TO-FACE REQUIREMENT

Question. The Affordable Care Act includes a provision that requires a physician or other authorized provider have a face-to-face encounter with a beneficiary in

order to certify eligibility for home health services. This is a well-intentioned provision of the law aimed at not only ensuring beneficiaries are accurately being referred to the proper care setting, but also to help reduce the potential for waste, fraud and abuse within the home health benefit. The implementation of the face-to-face requirement, however, has been difficult on both home health providers and ordering providers and has included several iterations of the requirements necessary to satisfy this provision of law, including at least one which was so onerous CMS rescinded it entirely.

Recently, CMS released a draft of a "template" designed to be used by physicians when documenting the face-to-face encounter. While this template is still being developed, there are some ongoing issues with the existing face-to-face requirements that needs to be addressed.

What steps is CMS taking to actively engage with stakeholders—home health agencies, physicians and Medicare Administrative Contractors—during the development of the recently announced face-to-face template as well as to educate them prior to the full implementation of the template?

Answer. CMS plans to conduct outreach and education with physicians, Home Health Agencies, hospitals, post-acute facility discharge planners, and non-physician practitioners via Open Door Forum calls to discuss the draft clinical templates.

Question. Does CMS plan to provide any transition time, including any moratoria on audits based on the face-to-face requirement, prior to the template taking full effect?

Answer. CMS simplified the face-to-face encounter documentation requirements by eliminating the specific face-to-face narrative requirement, in order to reduce administrative burden, and provide home health agencies with additional flexibility. CMS will use documentation from the certifying physician's medical records, and/or the hospital or post-acute facility's medical records, for beneficiaries as the basis for certification of home health eligibility. This simplification was finalized after public comment in the Calendar Year 2015 Home Health Prospective Payment System final rule (79 FR 66031). The use of the template is voluntary and CMS believes the use of clinical templates may reduce burden on the physicians and practitioners who order home health services.

Question. There is currently a three-year backlog of home health claims resulting from the face-to-face requirement's lack of finalization. How does CMS expect to clear out this backlog? Are there any plans to provide settlement options to home health agencies and, if so, what timeframe will CMS offer the settlements and how does it plan to calculate the settlement amounts?

Answer. The majority of CMS contractors at the first and second level of the appeals process are processing appeals timely and do not have backlogs. Although there are backlogs at the third and fourth levels, we cannot separately calculate the home health appeals backlog or confirm that the face-to-face requirement is at issue in all of the pending home health appeals without manual reviews of the case files.

The Department has a three-pronged approach to addressing the increasing number of Medicare appeals and the current backlog of claims to be adjudicated. First, invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog. Second, take administrative actions to reduce the number of pending appeals and more efficiently handle new cases that are entering the appeals process. Third, pursue legislative proposals described in the President's FY 2016 Budget that provide additional funding and new authorities to address this urgent need.

HOSPITAL SHORT STAYS AND THE TWO-MIDNIGHT RULE

Question. During the hearing, I raised my concerns about the so-called two-midnight rule and what steps CMS has taken to ensure that the compliance with, and enforcement of, the rule is feasible when the current statutory enforcement delay expires on March 31, 2015.

Can you provide specifics on the steps CMS has taken to engage with stakeholders—physicians, hospitals, audit contractors, etc.—to further develop a hospital inpatient short-stay policy?

Answer. After finalizing the two-midnight rule effective beginning FY 2014, CMS sought comments in the FY 2015 Inpatient Prospective Payment System (IPPS) proposed rule on an alternative payment methodology under the Medicare Program for

short hospital stays. Topics for comment included the definition of short or low cost inpatient hospital stays and the determination of appropriate payment for short inpatient hospital stays. We received a number of comments indicating that any short-stay policy should adhere to certain general principles and that additional research and collaboration were needed before a formal short-stay policy proposal were to be made by CMS. CMS noted in the FY 2015 IPPS final rule that there was no consensus among commenters. Although there was no consensus, CMS stated it would take the comments into account in any potential future rulemaking to address the complex question of payment policy for short inpatient hospital stays.

CMS has undertaken extensive efforts to engage with stakeholders directly on efforts to comply with the 2-midnight rule, including numerous "Open Door Forums" and national provider calls.

In addition, CMS instructed Medicare Administrative Contractors (MACs) to conduct "probe and educate" reviews for inpatient claims with dates of admission between October 1, 2013 and March 31, 2014, to assess provider understanding and compliance with the new policy. The Protecting Access to Medicare Act of 2014 (Pub. L. 113–93) permitted CMS to continue medical review activities under the MAC probe and educate process through March 31, 2015 and precluded recovery auditors from conducting post-payment patient status reviews for inpatient claims through March 31, 2015. All MACs have completed the first round of probe reviews and provider education. Throughout the probe and educate process to date, CMS has seen positive effects and improved provider understanding of the 2-midnight rule. We believe that this process has been well-received and beneficial to the provider community.

Recovery auditors may continue to conduct CMS-approved claim reviews, unrelated to the appropriateness of the inpatient admission (that is, patient status). In response to industry feedback, on December 30, 2014, we announced a number of changes to the Recovery Audit Program, including changing the recovery auditor "look-back period" to 6 months from the date of service for patient status reviews, in cases where the hospital submits the claim within 3 months of the date of service, to address hospital's concerns that they do not have the opportunity to rebill for medically necessary Part B inpatient services by the time a medical review contractor has denied a Part A inpatient claim. Additional changes intended to address stakeholder concerns were announced, including: new additional documentation request limits based on a provider's compliance with Medicare rules; incremental application of limits for providers that are new to recovery auditor reviews; requiring diversification of limits across all claim types for each facility; requiring recovery auditors to complete complex reviews within 30 days, and if recovery auditors fail to complete the review in 30 days, not allowing them to receive a contingency fee even if they find an error; and requiring recovery auditors to wait 30 days, to allow for a discussion period request, before sending a claim to the MAC for adjustment.

Question. What is the timeline CMS has for any new inpatient short-stay policy to be fully developed and implemented?

Answer. CMS solicited comments in the FY2015 IPPS proposed rule on an alternative payment methodology under the Medicare program for short inpatient hospital stays. As noted in the FY 2015 IPPS final rule, although stakeholders were not able to come to a consensus, CMS will take the comments into account in any potential future rulemaking to address the complex question of payment policy for short inpatient hospital stays.

Question. Will CMS continue to administratively delay enforcement of this rule after March 31, 2015, until such time that policy is in place?

Answer. Because of Congressional action, Recovery Auditors are currently prohibited from conducting post-payment inpatient hospital patient status reviews for claims with dates of admission from October 1, 2013 through March 31, 2015.

Question. I am concerned with the ongoing enforcement delay's impacts on the ability for Medicare to recover improper payments, but clearly the status quo two-midnight rule is failing and leading to a significant backlog of audit appeals. The administration offered to settle pending claims with hospitals as a way to alleviate this appeal backlog. The deadline for hospitals to accept this settlement was October, 2014.

How many of the pending appeals have been settled, or are in the process of being settled? What has been the subsequent impact of these settlements on the ability of the Administrative Law Judges to process the still-pending appeals?

Answer. The Department has a three-pronged approach to addressing the increasing number of Medicare appeals and the current backlog of claims to be adjudicated. First, invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog. Second, take administrative actions to reduce the number of pending appeals and more efficiently handle new cases that are entering the appeals process. Third, pursue legislative proposals described in the President's FY 2016 Budget that provide additional funding and new authorities to address this urgent need.

The settlement provides an opportunity for the government to reduce the pending appeals backlog by resolving a large number of homogeneous claims in a short period of time. In addition, it allows hospitals to obtain payment now for rendered services, rather than waiting an extended period of time, with the additional risk of not prevailing in the appeals process. HHS is still in the process of verifying and completing the review of the claims submitted for settlement.

Question. Can you provide an estimate of the total costs associated with the two-midnight rule, including negative impact on the recovery of payments for issues unrelated to inpatient short-stays, costs associated with the overwhelmed appeals process, and the lack of potentially legitimate payment recovery resulting from CMS's settlement offer?

Answer. In the FY 2014 IPPS/LTCH PPS final rule, our actuaries estimated that our policy would increase IPPS expenditures by approximately $220 million. These additional expenditures result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving to the IPPS from the OPPS, and some encounters of less than 2 midnights moving from the IPPS to the OPPS. CMS actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the hospital inpatient encounters.

In light of the widespread impact on the IPPS of this policy and the systemic nature of the issue, in the FY 2014 IPPS/LTCH PPS final rule, we stated our belief that it is appropriate to propose to use our exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the Act to offset the estimated $220 million in additional IPPS expenditures associated with this proposed policy and applied a −0.2 percent adjustment to the operating IPPS standardized amount, the hospital-specific rates, and the Puerto Rico-specific standardized amount.

To more quickly reduce the volume of inpatient status claims currently pending in the appeals process, CMS offered an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68 percent of the net allowable amount). HHS is still in the process of verifying and completing the review of the claims submitted for settlement.

MEDICAID ENROLLMENT BACKLOG

Question. As we discussed during the hearing, New Jersey continues to face a serious problem processing Medicaid applications in a timely manner. While it is my understanding that, as you stated, significant progress has been made processing Medicaid applications submitted through the Marketplace website, there is still a problem with applications submitted directly to the state or through the County Welfare Agencies. This delay is preventing a substantial number of Medicaid-eligible New Jerseyans from accessing the care they need and deserve.

What specific steps has CMS taken to help alleviate this enrollment backlog, including working with the state and counties to update and overhaul their eligibility and enrollment process?

Answer. CMS and the state have worked together in order to mitigate systems challenges. When the state knew they were unable to accept and process account transfers in late 2013, they worked with CMS to leverage authority to enroll individuals through a weekly file sent by CMS to the state, ensuring that individuals applying through the FFM would be enrolled in coverage in an expeditious manner. The file contains a subset of the application information, and the state developed a process to be able to pull the information into its system to complete the enrollment for the appropriate individuals.

New Jersey also has experienced challenges with processing the volume of applications that it receives directly from applicants. To help alleviate this backlog the state used the additional resources of its Health Benefits Coordinator to assist with the processing of applications. To help support this effort, it incorporated an open

source tool developed with HHS support so eligibility determinations could be automated. The State is working hand in hand with the counties to identify backlogged applications and to shift the processing of those applications to the Health Benefits Coordinator. The Health Benefits Coordinator is also processing all online applications and many of the redeterminations. The Health Benefits Coordinator has hired 100 additional people to process applications.

The state also requested and received a waiver to enroll individuals in Medicaid based on a preliminary finding of eligibility and then to complete the determination within 120 days of initial enrollment. Lastly, CMS granted the state a waiver to delay the processing of redeterminations in 2014 so that it could focus on the processing of new applications.

Question. Since it is taking a substantially than the maximum allowed 45 days for New Jersey to process applications, what is CMS doing to ensure that individuals who have applications pending beyond that 45-day deadline are informed of their application's status?

Answer. CMS is working closely with the state to improve their application processing timelines and have granted the state flexibilities through the use of waivers to ensure timely processing of applications.

Question. Does CMS ensure that these individuals receive, at a minimum, provisional benefits until their application is processed and they are fully enrolled?

Answer. Yes, CMS granted the state a waiver to allow them to enroll individuals in Medicaid based on a preliminary finding of eligibility and then to complete the eligibility determination within 120 days of initial enrollment. This allows that individuals who are found eligible based on a preliminary determination can access care while they await a final eligibility determination.

Question. In order for an individual to be eligible to receive an advanced premium tax credit (APTC) for coverage through the Marketplace they must not be eligible for Medicaid coverage. Because of the application backlog there are many individuals are unable to access an APTC because they haven't been formally denied access to Medicaid.

What steps is CMS taking with states to ensure that individuals who are not eligible for Medicaid are able to verify their Medicaid ineligibility and access an APTC for Marketplace coverage?

Answer. The state must notify the individual of their ineligibility for Medicaid or CHIP through the standard notice process and transfer their application to the Marketplace as appropriate. Given that New Jersey lacks the functionality to transfer applications back to the Federally Facilitated Marketplace, information on how to contact the Marketplace to enroll in coverage is included in their denial notices. However, CMS is working closely with the State to improve their enrollment processes and develop this functionality.

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

EXPANDING PACE ELIGIBILITY AND ALLOWING PACE INNOVATION

Question. As Governor, I worked on the development of the Program for All-inclusive Care for the Elderly (PACE) program in Delaware. It is a very high-value, cost-effective model that provides fully-integrated care for very frail seniors. PACE provides a comprehensive package of coordinated care and services to individuals who are 55 or older—and does so in a capitated payment arrangement.

I was pleased to see the Administration's proposal to expand PACE to serve younger individuals with disabilities and other high-risk populations. The PACE model for providing care and services is a good fit for this younger, qualified population.

I have two questions regarding PACE:

First, with regard to the proposed pilot program, it is my understanding that the Centers of Medicare and Medicaid Innovation is already considering a demonstration project to do just that.

Answer. As you noted, the President's Fiscal Year 2016 Budget includes a legislative proposal to create a pilot demonstration to test whether the PACE program can effectively serve a younger population without increasing cost. In developing this

proposal, we have considered whether there are non-statutory avenues for conducting a similar demonstration, and believe that legislative authorization is the best option for moving forward.

Question. Can you tell me more about the demonstration; what the agency is going to move this initiative forward; and when we might expect an RFP?

Answer. As noted above, we continue to believe that statutory authorization of a demonstration is the best option for moving forward at this time.

Question. Secondly, the PACE program is a value-based model that should be able to innovate and expand just as all providers of care and services are being asked to do as part of our health care system's shift to payment for quality. However, the program needs long-awaited revised regulations to allow this increased efficiency and innovation to occur. In its fall 2012 Regulatory Agenda, CMS published that a Notice of Proposed Rulemaking to revise the PACE regulation would be issued in July 2013. Since then, this deadline has been extended to December 2013, again to August 2014, and most recently, to Spring 2015. This delay creates numerous burdens for the PACE community and stifles their ability to innovate and grow.

What assurances can you offer that CMS will meet its own deadlines and issue a revised PACE regulation this spring?

Answer. CMS is currently performing a comprehensive review of the federal regulations governing PACE to identify potential regulatory changes to reflect the evolving needs and opportunities of the program. As CMS continues to contemplate potential regulatory changes, they have implemented a number of improvements to PACE, including streamlining the application process, updating the notification requirements for the use of alternative care settings, and establishing a new PACE council to bring together different components of the agency to focus on PACE issues.

MEDICARE COVERAGE FOR TREATING OBESITY

Question. This summer, it will be two years since the American Medical Association classified obesity as a disease and called on patients, health care providers, insurers, and policymakers to take this epidemic seriously. More than two-thirds of all American adults are affected by being overweight or obese, and excess weight increases the risk of diabetes, heart disease, stroke and other illnesses. Medical costs are directly proportional to body mass index, which is the leading indicator of obesity.

In light of this epidemic, we need an "all hands on deck" approach to treating obesity, not the piecemeal approach we currently pursue. The guiding principle for us should be to provide physicians with the means to make every treatment regimen available to those individuals fighting obesity. This is why we need to make two important changes to Medicare: first we need to expand access to weight management counseling for those who with overweight or obesity. And second, the coverage ban on FDA-approved obesity drugs under the Medicare prescription drug program must be lifted.

I know you and the Administration share Congress's concern about the climbing rates of obesity in our country and the concurrent cost implications. Please report back to the Committee any data, analyses and/or information the Chief Actuary or others at HHS might have that sheds light on how those who are obese or overweight drive costs to both the Medicare and Medicaid programs.

Answer. The Department shares your concern about obesity. Currently, the Office of the Assistant Secretary for Health convenes an HHS inter-agency workgroup on Healthy Weight, Nutrition and Physical Activity (HWNPA). This group meets monthly and representatives from across HHS share information on their agencies' HWNPA activities, which range from school nutrition, childhood obesity, and healthy weight measures to walking and walkability. CMS is part of this workgroup.

Currently, Medicare covers several types of bariatric surgery for beneficiaries with a Body Mass Index (BMI) of 35 or greater and at least one co-morbidity related to obesity who have previously been unsuccessful with medical treatment for obesity. Medicare also covers intensive behavioral counseling for obesity for individuals with a BMI of 30 or greater.

There have not been many studies to date examining how increasing rates of obesity have affected Medicare or Medicaid costs. A paper published in Health Affairs

in 2009 by Finkelstein and colleagues estimated that, in 2006, $147 billion in national health expenditures was attributable to obesity, including $34.3 billion for Medicare and $27.6 billion for Medicaid. Another review paper by Tsai and colleagues in 2010 put total obesity-related spending in 2008 at $114 billion.

REDUCING IMPROPER PRESCRIPTIONS OF PSYCHOTROPIC MEDICATIONS TO FOSTER CHILDREN

Question. In your testimony, you mentioned a ten-year program that would help children in foster care access the mental health services they need. As you are aware, children in foster care are often prescribed mind-altering medications to treat their behaviors. Experts say that these medications can have harmful effects in the long term, and that they may be less effective than therapies or other treatments to address emotional trauma. Additionally, these prescriptions are very costly, sometimes costing more than $532 million per year in Medicaid expenses for prescriptions to foster children alone.

I was very pleased to see that the Administration is making access to effective mental health treatment for foster children a priority. The demonstration program that this proposal would fund would provide states with important tools to improve mental and behavioral health care for children in foster care, through increased use of effective screening and assessment, and evidence-based treatment of trauma, along with emotional and behavioral disorders. That program would be jointly administered through the Administration for Children and Families (ACF) and the Centers for Medicare & Medicaid Services (CMS), two agencies within the Department of Health and Human Services.

Given the strengths of the proposed demonstration, I would like to know:

First, are there any activities outlined in the proposal, including providing incentive grants to states that CMS and ACF cannot undertake without Congressional action, such as legislation to allow new authorities?

Answer. Neither ACF nor CMS can pay incentive payments as envisioned in the proposal without both authorization and appropriation.

If authorized without sufficient funding, ACF would have the authority to provide for the child welfare workforce, training, and evaluation pieces of this proposal under the authority of existing grants under title IV–B–1 and IV–B–2 of the Social Security Act, but would only be able to fund these efforts by reducing expenditures for important existing activities including the National Survey of Child and Adolescent Well-Being (NSCAW), national training and technical assistance for improving state and tribal child welfare systems, and various grant opportunities for child welfare professionals and students. However, as these are appropriated funds, this would involve significant trade-offs, with less funding available for existing activities including the National Survey of Child and Adolescent Well-Being (NSCAW), national training and technical assistance for improving state and tribal child welfare systems, and various grant opportunities for child welfare professionals and students.

This proposal will help encourage States to implement evidence-based psychosocial interventions targeting children and youth in the foster care system, as an alternative to the current over-prescription of psychotropic medications in this population. However, we are working with States to identify ways to strengthen their efforts to address this issue today. In terms of monitoring, CMS has encouraged states to use their Medicaid Drug Utilization Review (DUR) programs to intensify the oversight of prescribing psychotropic medications to children. States are employing a variety of techniques in this area. Some states have a system by which a prescription for a psychotropic medication in a child triggers a preauthorization which requires a manual review of the prescription request by a panel of experts of a multi-disciplinary team, a psychiatrist or by the Medicaid agency's pharmacy staff. Other states require that, for children under certain ages (e.g. under age five, under age six, under age seven, etc.), the prescriber is required to complete a form providing prescriber information, patient diagnosis, target symptoms being treated, other drugs prescribed and laboratory tests.

Question. Secondly, which activities, if any, require legislation?

Answer. The incentive payments would require both authorization and appropriation for ACF and CMS. Using existing grant authority under the Social Security Act as described above would require appropriations to fund the appropriate portions of the proposal.

QUESTIONS SUBMITTED BY HON. JOHN CORNYN

KING V. BURWELL

Question. Has the Department of Health and Human Services (HHS) taken steps to inform all current federal exchange enrollees and all visitors to *HealthCare.gov* about the King suit and how a ruling against the Administration could affect them?

Answer. It has not.

Question. What are your agency's contingency plans to ensure that people inappropriately subjected to the individual and employer mandates and associated tax penalties are not punished further?

Answer. We are confident that we will prevail because the text, structure, and history of the Affordable Care Act make clear that tax credits are available to people in all states.

Question. Do you plan to ask Congress for a legislative solution?

Answer. We are confident that we will prevail because the text, structure, and history of the Affordable Care Act make clear that tax credits are available to people in all states.

Question. Do you believe you have the authority to make an administrative fix?

Answer: We know of no administrative actions that would undo the massive damage to our health care system that would be caused by an adverse decision and, therefore, we have no plans that would undo the massive damage. If the Supreme Court says we have no authority to provide tax credits for citizens in States with federally-facilitated Exchanges, we cannot provide them in such states.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH (NIOSH)

Question. As you already know, one of my priorities for FY2016 is to find and prioritize funding necessary to identify and acquire a new NIOSH facility in Cincinnati, Ohio.

NIOSH's mission is to "prevent work-related injury, illness, and death." In Cincinnati, NIOSH research and support activities are located on two separate campuses, approximately eight miles apart. Both campuses are comprised of aging 1950s-era facilities that are in varying states of disrepair, and are increasingly deficient in both space configuration and building systems. Because of this, scientific collaboration is limited and NIOSH's cutting-edge scientific research is inhibited. Upgrading these facilities is of paramount importance, and should be a funding priority.

Funding for a new facility for NIOSH was not included in the FY2016 proposed budget. Will there be funds left over from FY2015 that NIOSH could use to begin this project? As you work with the Office of Management and Budget (OMB) on this issue moving forward, do you have a start date or location in mind?

Answer. HHS is supportive of the critical work being conducted at NIOSH's Cincinnati campuses. The Department's FY 2015 Nonrecurring Expenses Fund allocation includes $110 million to fully fund the Cincinnati consolidation project. CDC has already engaged the General Services Administration to secure acquisition services to support the site solicitation process. Public responses to the site solicitation will identify potential facilities for CDC's consideration; solicitation responses are currently projected for FY 2016. The solicitation's delineated search area will include the greater Cincinnati area. I would be happy to keep you informed about the Department's continued work on selection of a site and relocation/consolidation.

ANTIBIOTIC RESISTANCE

Question. Last year, the CDC came out with a report conservatively estimating that more than two million people are sickened each year with antibiotic-resistant infections—resulting in at least 23,000 deaths a year. I am pleased that the Administration has proposed an increase in funding to strengthen the federal response to antibiotic resistance (AR) and help combat this public health crisis.

I commend the Administration for investing more in AR surveillance, research, and stewardship, and I am eager to know more about the Administration's plan to

combat AR going forward. Next week, the President's Task Force for Combating Antibiotic-Resistant Bacteria is scheduled to submit its 5-year National Action Plan to the President outlining specific actions to be taken to implement a National Strategy for Combating Antibiotic-Resistant Bacteria. What will be the Agency's role in implementing this Strategy?

Answer. The *National Action Plan for Combating Antibiotic Resistant Bacteria* will outline steps for implementing the *National Strategy for Combating Antibiotic-Resistant Bacteria* and addressing the policy recommendations of the President's Council of Advisors on Science and Technology (PCAST) report on *Combating Antibiotic Resistance.* The National Action Plan will outline federal activities over the next five years to enhance our domestic and international capacity to prevent and contain outbreaks of antibiotic-resistant infections, maintain the efficacy of current and new antibiotics, and develop and deploy next-generation diagnostics, antibiotics, vaccines, and other therapeutics. These activities are consistent with investments proposed under the FY 2016 President's Budget request, which nearly doubles the amount of Federal funding for combating and preventing antibiotic resistance to more than $1.2 billion.

The FY 2016 budget request would support implementation of activities in *CDC's FY 2016 AR Solutions Initiative,* an increase of $264 million, which will build a more robust network to improve detection for all of the antibiotic resistance (AR) threats outlined in *CDC's AR Threat Report* and protect patients and communities from all of these threats—saving lives, and reducing costs. CDC plans to award more than 85 percent of AR Solutions Initiative funding to states, communities, healthcare providers, universities, and other groups to implement these activities.

CDC's FY 2016 budget request supports comprehensive tracking of AR infections, rapid detection, and faster outbreak response by leveraging existing detection programs and capabilities to:

- Establish state AR prevention programs dedicated to improving outbreak detection across healthcare facilities and in communities, improve antibiotic prescribing, and prevent AR infections and *Clostridium difficile.*
- Establish a *"Detect" network of up to seven regional laboratories* that will serve as a national resource to characterize emerging resistance and rapidly identify outbreaks of AR threats using state-of-the-art methods to characterize known resistance patterns in real time and identify clusters of resistant organisms more quickly. It will also track the spread of AR organisms in communities and through food to people. This will dramatically improve our understanding of which AR threats are most common in the United States, and which will be critical for new drug and diagnostic development. This network will also provide rapid analysis of local, state, and national-level resistance trends, and rapid dissemination of findings.
- As AR threats change, CDC will tailor the testing protocols of the labs to adapt to new and emerging threats. To ensure that key stakeholders are aware of current AR threats, CDC will establish an AR isolate library that will be accessible to pharmaceutical companies and researchers testing new antibiotic agents, and biotech and diagnostic companies designing the next generation of clinical tests.
- Expand the use of *National Healthcare Safety Network's Antibiotic Use and Antibiotic Resistance* reporting options to track antibiotic use and AR infections in over 90 percent of eligible hospitals. These data allow hospitals to target prevention efforts and assess the quality of antibiotic prescribing to improve how antibiotics are used in U.S. healthcare facilities.
- Double from 10 to 20 the number of *CDC's Emerging Infections Program (EIP)* sites to expand population-based AR assessments and faster assessments of risk to specific populations in the community and in healthcare.

Question. Last year, I re-introduced the *Strategies to Address Antimicrobial Resistance (STAAR) Act,* which would strengthen the federal response to AR by reauthorizing the Interagency Task Force on Antimicrobial Resistance (ITFAR) and allowing the CDC to partner with state health departments to implement prevention collaboratives, and to expand public health partnerships through the CDC's established Prevention Epi-Centers work. I plan to reintroduce similar legislation later this year to compliment the National Action Plan and National Strategy in combating AR.

How could an updated version of the STAAR Act help compliment the National Action Plan and implement a National Strategy? How could the budget's increase

in funding to combat AR bolster the STAAR Act's potential to coordinate a federal response to this public health crisis?

Answer. To support the *National Strategy on Combating Antibiotic-Resistant Bacteria,* CDC is working to address the threat of antibiotic resistance (AR) in four areas. These four areas touch on similar activities outlined in the STAAR Act:

1. Slowing the development of resistant bacteria to prevent the spread of resistant infections.

- Supports regional prevention collaboratives between the CDC and state health departments to interrupt and prevent the transmission of significant AR pathogens being transferred across health care settings in a geographic region.
- Intensifies and expands academic public health partnerships through the work of CDC's Prevention Epicenters to support the evaluation of interventions to prevent or limit AR.
- Improves the use of antibiotics by supporting CDC's work with standard setting organizations such as the National Quality Forum to benchmark appropriate antibiotic use and to assess the impact of antimicrobial stewardship programs.

2. Strengthening the national one-health surveillance efforts to combat resistance.

- Intensifies and expands CDC's current efforts to collect AR data to monitor theemergence and changes in patterns of AR pathogens.

3. Advancing the development and use of rapid and innovative diagnostic tests for identification and characterization of resistant bacteria.

- To ensure that key stakeholders are aware of current AR threats, CDC will establish an AR isolate library that will be accessible to pharmaceutical companies and researchers testing new antibiotic agents, and biotech and diagnostic companies designing the next generation of clinical tests.

4. Improving international collaboration and capacities for antibiotic resistance prevention, surveillance, control and antibiotic research and development.

- Under the national strategy, CDC will develop a communications network to improve the linkage of domestic and international AR labs to track urgent and emergent AR pathogens across borders.

MEDICATION THERAPY MANAGEMENT

Question. CMS recently released a rule related to the Part D program, which finalized several of the remaining provisions from the proposed Part D rule from last year. One of the provision from last year's proposed rule that was not finalized looked to increase the number of beneficiaries eligible for medication therapy management services. MTM has been shown to improve patient health while at the same time reducing costs, so increasing access to these services makes sense.

Can you comment on the importance of the Part D MTM program as well as on HHS's plans for making meaningful changes to the Part D MTM program? Do you agree that HHS should finalize this part of the rule to increase the number of beneficiaries eligible for MTM services?

Answer. Part D MTM programs are important to improve quality, reduce adverse events, and improve therapeutic outcomes for enrollees. Despite the comments to the proposed rule from those who supported the proposed changes in eligibility criteria, we also considered the comments that the timeline for implementing the proposed changes was too aggressive and could negatively affect existing MTM programs. While our goal was to increase eligibility and access to MTM, we did not want to do it at the expense of sacrificing any quality with existing programs. Therefore, we did not finalize our proposed changes to the eligibility criteria.

CMS is conducting several evaluations of MTM programs: (1) Evaluation to consider revisions of MTM eligibility criteria and to identify effective outreach strategies; (2) MTM Improvements project to improve the standardized format for the CMR written summary; and (3) a Center for Medicare and Medicaid Innovation model in development to test regulatory flexibilities and payment incentives for more robust and effective MTM programs. Based on the outcomes of these evaluations, CMS could engage in new notice and comment rulemaking.

ESRD FIVE STAR PROGRAM

Question. I am concerned about CMS's methodology behind the new End Stage Renal Disease (ESRD) Five Star program. As I understand it, the current design of the program distorts actual dialysis facility performance by forcing facility scores onto a hard bell curve. This method exaggerates small differences in performance and skews hard data around a center peak. As a result, states like Ohio have seen over 47% of our dialysis facilities become 1 and 2 star facilities. It is important that this program be effective and accurate.

These Star rankings fail to reflect the actual performance of dialysis facilities and provide oftentimes inaccurate and misleading information to patients. CMS even admits in their responses to questions about the new star rating system that "1 or 2 star facilities are not necessarily the facilities that provide poor service." Adding to the confusion, the new star rankings and the Quality Improvement Program (QIP), mandated by Congress, are inconsistent and, from a consumer's perspective, can be in direct conflict. For example, 47.37% of Ohio's facilities are labeled as 1 Star or 2 Star facilities, yet 1.05% received a penalty of −2% or −1.5% (the bottom two of five penalty categories).

5. What process has CMS has used in developing the Dialysis Five Star program?

Answer. Information obtained from CMS consumer testing focus groups revealed that the use of star ratings is more easily interpreted by dialysis patients and their families than the information previously available on Dialysis Facility Compare (DFC). In developing the Five Star program, CMS first reviewed existing star-rating methodologies, such as the Nursing Home star-rating system. CMS sought to be consistent with that methodology, but to also learn from its implementation. CMS also considered the implications of having a more limited set of available measures derived from different data sources than could be found for nursing homes.

The methodology depended on quality measures already publicly reported on DFC, in some cases for more than a decade, with the expectation that additional data and measures could be considered in future iterations. CMS assessed existing measures for appropriateness and removed those on which all providers performed highly since these were not useful in distinguishing differences in care. This left the current set of nine quality measures.

CMS developed the scoring methodology through a process that considered alternative approaches, many of which have been suggested by the dialysis provider community. Their specific methodological design and supporting analyses were documented in a technical report and a series of FAQs that are available to the public for review. CMS presented the star rating methodology in July 2014 and shortly thereafter provided preview reports to dialysis facilities for their review and comment. They received extensive comments from the community over the next several months and delayed the posting of the ratings from October 2014 until January 2015, in part to consider concerns and to respond in writing and through a series of public and private meetings with stakeholders. After considering those concerns, CMS determined that the star ratings methodology was appropriate to the task of providing patients and other consumers with reliable and valid summary data on the quality of care received at dialysis facilities. CMS implemented the star ratings in January 2015.

CMS took steps to address concerns regarding the interpretation of the data after speaking with patient advocates and conducted additional testing to ensure messaging of the star ratings was appropriate for patient needs. CMS also modified descriptive language on the DFC website, in direct response to suggestions made by patients and patient advocates.

Moving forward, in an effort to continuously improve, CMS decided to use a Star Rating Technical Expert Panel (TEP) to more formally incorporate public input into the methodology, and to drive the prioritization of additional measures and data with a focus on patient and consumer needs. This culminated in the announcement of a TEP in early October 2014, and the distribution of a call for nominations of TEP members from the public in early 2015. CMS's contractor is preparing to convene the TEP in a series of meetings that are open to the public.

Question. Unlike the development of the nursing home five star program, where a technical expert panel (TEP) was convened to help design the system, CMS convened no TEP and relied on no stakeholder input to design the Dialysis Five Star program. In addition, although CMS encouraged input when announcing its Dialysis Five Star program, CMS said that it would not consider any input until the program

was updated. What was the rationale behind requesting input, but refusing to consider it?

Answer. While CMS did not initially convene a TEP specific to the star ratings for Dialysis Facility Compare, feedback obtained from stakeholders and from the development of consumer websites in general was considered in the design. CMS also recognized early in the process that Star Ratings for DFC would be an iterative process that requires periodic updating and maintenance. This would be necessary when new measures became available, when old measures appeared to top out, or methodological weaknesses in the scoring approach were identified. It was not clear when CMS began developing the star ratings whether a TEP would be necessary or appropriate, given the limited availability of measures for dialysis facilities. Prior experience with star ratings and the limited information available for inclusion originally suggested that an initial run of the star ratings could be developed internally and then improved upon with public feedback.

The Star Ratings were announced in July of 2014 accompanied by the request for feedback from all stakeholders. CMS delayed posting of the star ratings in order to give more time for stakeholders to meet with CMS officials and to provide detailed input. CMS made it clear at that time that it would consider all feedback prior to moving forward. In fact, information from the community was considered, alternative models where explored and after consideration was given to all factors, it was determined that the model selected was the most appropriate for the current time. Recognizing that the rating system is evolutionary and the need to continually include more data, CMS decided that a TEP would be appropriate as we consider future iterations of the program. As CMS's contractor has prepared to convene the Star Ratings TEP, they continue to speak regularly with stakeholders, including patients, patient advocates, professional associations, and dialysis providers. The contractor will be presenting much of the feedback we've received to the TEP to inform their deliberations on scoring methodology, measure prioritization, and communications, as well as other issues that may arise.

Question. Just recently, CMS announced it is convening a dialysis TEP. However, it does not seem that CMS has provided stakeholders or patients with reasonable advanced notice or adequate time to submit materials to the TEP for review and consideration as CMS seeks to revise the Five Star program for 2016. It is critical that we give patients, nephrologists, nurses and others a voice in this process and even more critical that we consider recommendations that will allow the Five Star program to accurately measure performance. In the interest of transparency, what is CMS doing to ensure the engagement of outside experts and input from patients in the effort to revise the ESRD Five Star program for 2016? What level of transparency can we expect moving forward?

Answer. We agree that reviewing and considering the recommendations of stakeholders is critically important. CMS has frequent listening sessions with nephrologists, nurses, patients and others that are critical to the provision of ESRD care. The TEP provides a valuable opportunity to further incorporate external input from key stakeholders including statistical methodologists, clinical nephrologists, nephrology nurses, and a large number of dialysis patients.

CMS announced in October 2014 that a contractor would convene the TEP, representing 2–3 additional months of notice beyond what is typical when we announce the formation of a TEP, so we believe that we have given stakeholders ample time to provide us with their recommendations and detailed methodologies. CMS' contractor is taking care to present alternative methodologies to the TEP alongside the existing Star Rating methodology, accompanied by extensive analyses assessing stakeholder concerns. These materials are not privately held and may be accessed by the community. Many of these are already available via our FAQ documents.

The TEP will meet in-person in the spring of 2015 to consider the methodological issues raised by the community, and to make suggestions about future modifications to the scoring methodology, quality measure set, and other related issues.

MEDICARE PART D PLAN FINDER

Question. Over the last several weeks, it has come to my attention that hundreds of thousands of Medicare beneficiaries who chose Part D plans for 2015 have had trouble accessing their medications because of a mistake that was made as one particular insurance company created its pharmacy networks. As I understand the situation, incorrect information was posted on Medicare plan finder throughout open enrollment as well as provided by insurance company regarding where seniors could

have their prescriptions filled. As a result, many pharmacies were listed on Medicare's plan finder and on the company's website as being "in network" when they were in fact out of network, creating chaos, consternation, and very real medication access/distribution issues for both pharmacies and their patients.

CMS acknowledged this issue in December, however no fixes were implemented until well into January. Why didn't the agency address before the new plan year started? What are you doing now to fix this issue and provide recourse for current beneficiaries? What measures will you put into place to ensure this does not happen to seniors moving forward?

Answer. CMS was alerted in late November 2014 to possible inaccuracies in the referenced Part D sponsor's network pharmacy information when they received a complaint from a pharmacy stating that its status as a network participant for the sponsor was reflected incorrectly on the Medicare Plan Finder (MPF). During their investigation of the matter, the plan sponsor acknowledged that it had provided inaccurate pharmacy network information to CMS for the MPF and in its own beneficiary communication materials. CMS acted promptly to address this issue by removing the sponsor's Part D plan information from display on the MPF in early December.

CMS's investigation also revealed that the sponsor's pharmacy contracting process had left many pharmacies confused about their participation in the sponsor's networks. CMS directed the sponsor to issue notices to all its contracted pharmacies explicitly identifying the plans for which they were network participants. In early January 2015, they also advised the sponsor to provide clear and binding offers of standard contracting terms and conditions for participation in all its plan types to pharmacies requesting them for CY 2015.

After the start of the 2015 benefit year, CMS began receiving numerous complaints through 1–800–MEDICARE from beneficiaries upset that their regular pharmacy was no longer participating in the Part D plan they had elected. CMS took two significant steps to address these complaints. First, beneficiaries were alerted that CMS would afford them a special election period during which they could pick a new plan for 2015 that included their pharmacy of choice in its network. Second, CMS required the sponsor to agree to pay in-network claims at all of the pharmacies with which it had contracted during 2014, until the sponsor conducted additional beneficiary and pharmacy outreach about the network changes and contracts with additional pharmacies that will accept standard terms and conditions.

CMS will continue to monitor the sponsor's performance closely to protect beneficiaries' access to their Part D benefits. CMS is also evaluating additional steps they may be authorized to take to reduce the likelihood of future inaccuracies in plan network information provided to beneficiaries. CMS has issued multiple compliance actions to the sponsor related to the erroneous information and the overall beneficiary disruption caused by these changes. Also, they have and will continue to advise pharmacy trade associations that they should pay close attention to the process for contracting with Part D sponsors and how their Part D participation information is represented by sponsors and on the Medicare Plan Finder.

QUESTIONS SUBMITTED BY HON. PAT ROBERTS

Question. Last year the Administration's Flexible Spending Account (FSA) regulations allowed employees to rollover up to $500 to the next plan year. Does the Administration support additional measures to make FSAs and HSAs more useful to the middle class, such as restoring over-the-counter (OTC) medicine eligibility without a prescription?

Answer. Regulations concerning the administration of Flexible Spending Accounts (FSAs) are within the purview of the Department of the Treasury, specifically, the Internal Revenue Service (IRS). This Administration is open to improving the Affordable Care Act as long as proposed changes enhance health care affordability, access, and quality and help the economy.

Question. Under the current Self-Referral Disclosure Protocol for Stark law violations, hospitals are awaiting decisions from CMS for what seems to be an excessive period of time for technical noncompliance (administrative mistakes, missing signatures, etc). How many self-referral disclosures are currently pending a settlement decision by CMS, and from how many hospitals? With a four year timeline for CMS

to reach a settlement, how many of these cases are nearing expiration without a resolution?

Answer. There are 400 disclosures pending settlement. Based on our experience to date, approximately 90 percent of disclosures involve hospitals. The four year look back period refers to the period of time during which a provider making a disclosure may not have been in compliance with the physician-self referral law, but is not a time limit for when a settlement must be reached. Once a provider of services or supplier electronically submits a disclosure under the Self-Referral Disclosure Protocol (SRDP) (and receives email confirmation from CMS that the disclosure has been received), the statutory obligation to return any potential overpayment within 60 days will be suspended until a settlement agreement is entered, the provider of services or supplier withdraws from the SRDP, or CMS removes the provider of services or supplier from the SRDP.

Question. Last year, CMS presented a global settlements offer and over 2,000 hospitals entered this process. How many acute hospital and critical access hospital claim denials were eligible for the settlement when it was extended, and how many of those have been settled thus far? For other hospitals not currently eligible for settlement, such as IRFs and LTCHs, how many denials for these hospitals are in the system?

Answer. The Department has a three-pronged approach to addressing the increasing number of Medicare appeals and the current backlog of claims to be adjudicated. First, invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog. Second, take administrative actions to reduce the number of pending appeals and more efficiently handle new cases that are entering the appeals process. Third, pursue legislative proposals described in the President's FY 2016 Budget that provide additional funding and new authorities to address this urgent need.

The settlement provides an opportunity for the government to reduce the pending appeals backlog by resolving a large number of homogeneous claims in a short period of time. In addition, it allows hospitals to obtain payment now for rendered services, rather than waiting an extended period of time, with the additional risk of not prevailing in the appeals process. HHS is still in the process of verifying and completing the review of the claims submitted for settlement.

Question. Since this settlement process was only open to Acute Care Hospitals and Critical Access Hospitals, will the same process be extended to all hospitals and other Medicare providers and suppliers? And if so, when?

Answer. HHS has no plans to extend the settlements at this time, but we will continue to pursue options to responsibly resolve the backlog of appeals.

The Department has a three-pronged approach to addressing the increasing number of Medicare appeals and the current backlog of claims to be adjudicated. First, invest new resources at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog. Second, take administrative actions to reduce the number of pending appeals and more efficiently handle new cases that are entering the appeals process. Third, pursue legislative proposals described in the President's FY 2016 Budget that provide additional funding and new authorities to address this urgent need.

Question. What oversight is being done on the Recovery Audit Program to ensure the RACs aren't adding to the backlog problem with inaccurate payment denials?

Answer. CMS strives to manage programs in an efficient manner that balances the need to limit burden on Medicare providers with our responsibility to protect Trust Fund dollars. CMS has carefully evaluated the Recovery Audit program, and announced a number of changes to it in response to industry feedback.[54] CMS is confident that these changes will result in a more effective and efficient program through enhanced oversight, reduced provider burden, and more program transparency. These changes will be effective with each new contract award beginning with the Durable Medical Equipment, Home Health and Hospice Recovery Audit

[54] See *http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf.*

contract awarded on December 30, 2014.[55] The President's FY 2016 Budget also includes a proposal to permit CMS to retain a portion of recovered funds to implement corrective actions identified through the Recovery Audit program.

CMS has many safeguards in place to ensure Recovery Auditors are not financially incentivized to inappropriately deny claims. For one, if the claim is overturned at any level of appeal, the Recovery Auditor does not receive a contingency fee payment. When Recovery Auditor determinations are in fact appealed, many of these decisions are upheld. Overall, only 9.3 percent of all Recovery Auditor determinations were challenged and later overturned on appeal in FY 2013. CMS also contracts with an independent entity that reviews a random sample of claims from each Recovery Auditor to establish an accuracy rate, which is a measure of the accuracy of each Recovery Auditor's overpayment and underpayment determinations. The combined accuracy rates for the Recovery Auditors are consistently above 90 percent. In addition, continued poor performance by a Recovery Auditor will result in negative performance evaluations and may result in work stoppage, corrective action plans and/or contract modification or termination.

Question. Providers are spending money on the appeals process—in essence spending money to get money back that was theirs in the first place. Are the auditors also spending money in the appeals process or are those costs covered by CMS? If covered by CMS, how much money is that, and is it being included in the cost-benefit analysis of the RAC program?

Answer. The Tax Relief and Health Care Act of 2006 gives CMS the authority to pay Recovery Auditors a contingency fee on recovered improper payments. All operating expenses incurred by RACs from activities conducted under the recovery audit program, including costs incurred by RACs to support the appeals process, come out of the contingency fee the Recovery Auditors receives for correcting the claim.

Question. As part of the Department's focus on delivery system reform, you highlighted an initiative that would change how doctors are paid for treating cancer patients. What safeguards will be included to ensure these patients can access treatments that are individualized to meet their health care needs and aren't steered towards other options purely based on cost?

Answer. We believe that oncology is an area of medicine where efforts to improve the quality and efficiency of care can have significant beneficial effects. Peer reviewed publications and Institute of Medicine reports both demonstrate areas where patient care can be improved. HHS believes that changing the way oncology care is paid for and delivered can both improve the quality of cancer care and reduce expenditures.

For each model that CMS tests, CMS includes a monitoring and evaluation effort to address issues of patient protection and safety, including continual assessment of quality of care. We monitor for issues related to patient safety, care stinting and patient access to care, patient freedom of choice, and provider induced demand for unnecessary care. The monitoring approach is multipronged and utilizes a variety of measures and data sources depending on the specifics of the model. CMS uses measures that provide information on patient case-mix, clinical quality process and outcomes, utilization patterns, and patient reported experience of care. Information comes from a variety of sources including claims, patient and proxy interviews, patient assessment information, and in qualitative sources such as site visits and interviews. These findings are tracked, examined and reviewed on an ongoing basis, typically quarterly. These efforts would allow us to quickly identify potentially negative shifts in patterns of care. The precise monitoring strategy adopted is tailored to the unique circumstances of every model. The choice of measures is a reflection of the possible provider behaviors that could result from the incentives being tested in that model.

Question. Last year, the Government Accountability Office found that individuals in five states did not have the option of purchasing an insurance plan through the marketplace that excluded elective abortion. For the 2015 enrollment period, there are still four states—Hawaii, New Jersey, Rhode Island, and Vermont—whose marketplaces only offer plans covering elective abortion. While at least one Multi-State plan is required to exclude it, not every state has MSPs yet. What plans are underway to ensure that individuals in these states are able to purchase a health plan

[55] Due to a post-award protest filed at the Government Accountability Office (GAO), CMS has delayed the commencement of work under the national DMEPOS/HH&H, Region 5, Recovery Audit contract.

that does not pay any amount towards elective abortion? Will you assure consumers that there will be a plan that does not cover abortion in each state by the 2016 open enrollment season?

Answer. Some of the issues raised by your question currently are the subject of litigation. The Department of Justice will address these issues in the course of the litigation as appropriate. In addition, the Affordable Care Act, which established the Multi-State Plan Program, directs the Office of Personnel Management (OPM) to contract with private health insurers to offer high-quality, affordable health insurance options called Multi-State Plans (MSP). A few states do not currently have a MSP plan option available for purchase on the Exchange in their States. As OPM is responsible for the administration of the MSP Program, if you have questions regarding the availability of MSPs, including the states in which they are available, those inquiries should be directed to OPM.

Question. The California Department of Managed Health Care (DMHC) issued a directive mandating that all health plans under its jurisdiction immediately include coverage for legal abortions in all circumstances. This includes plans provided by pro-life employers, churches and religious institutions and plans that were previously approved by DMHC that excluded some abortions. What action is HHS taking to ensure that the DMHC complies with the Weldon amendment?

Answer. HHS supports clear and strong conscience protections for health care providers and entities who are opposed to performing abortions. The HHS Office for Civil Rights (OCR) received three complaints alleging that the DMHC directive violates the conscience clause protections of the Weldon Amendment. OCR has opened an investigation to examine the allegations in these complaints and has been proceeding expeditiously. Because these are open cases, we cannot comment on the status of the review.

QUESTIONS SUBMITTED BY HON. PAT ROBERTS AND HON. JOHNNY ISAKSON

Question. As you know, there was an issue with some Medicare Part D drug plans listed on the Medicare Plan Finder website during the 2014 Medicare open enrollment period. Some seniors were given incorrect information regarding which pharmacies were in-network when selecting a plan last year. We appreciate CMS's efforts to work with us and our local pharmacists to establish a special enrollment period for Medicare Part D beneficiaries who enrolled in a plan that listed an incorrect pharmacy network on the Medicare Plan Finder. How does CMS ensure that the approved plan network is accurate when presented to beneficiaries during open enrollment? What rules are in place to ensure beneficiaries have access to a broad network of pharmacies?

Answer. The Part D statute requires Medicare prescription drug plans to afford their enrollees access to retail pharmacies in urban, suburban, and rural areas at rates equivalent to at least those applicable to the TRICARE program. To develop such a network, the statute authorizes Part D plan sponsors to contract with the pharmacies they select and with which they can negotiate mutually acceptable terms. A sponsor must also offer to any pharmacy making such a request the opportunity to participate in the sponsor's plan network under standard terms and conditions established by the sponsor.

CMS relies on each sponsor to provide beneficiaries and CMS with accurate pharmacy network information, including that used to populate the Medicare Plan Finder (MPF) website. CMS conducts an outlier analysis on pharmacy network and drug pricing information sponsors submit for the MPF to identify instances where a sponsor's submission may be inaccurate. While this outlier analysis is useful in supporting MPF accuracy, it cannot detect all inaccuracies in a sponsor's submission.

CMS was alerted in late November 2014 to possible inaccuracies in the referenced Part D sponsor's network pharmacy information when we received a complaint from a pharmacy stating that its status as a network participant for the sponsor was reflected incorrectly on the MPF. During our investigation of the matter, the plan sponsor acknowledged that it had provided inaccurate pharmacy network information to CMS for the MPF and in its own beneficiary communication materials. CMS acted promptly to address this issue by removing the sponsor's Part D plan information from display on the MPF in early December until it was cancelled in late December.

CMS's investigation also revealed that the plan sponsor's pharmacy contracting process had left many pharmacies confused about their participation in the sponsor's plan networks. CMS directed the plan sponsor to issue notices to all its contracted pharmacies explicitly identifying the plans for which they were network participants. In early January 2015, we also advised the sponsor to provide clear and binding offers of standard contracting terms and conditions for participation in all its plan types to pharmacies requesting them for CY 2015.

After the start of the 2015 benefit year, CMS began receiving numerous complaints through 1–800–MEDICARE from beneficiaries upset that their regular pharmacy was no longer participating in the Part D plan they had elected. CMS took two significant steps to address these complaints. First, beneficiaries were alerted that CMS would afford them a special election period during which they could pick a new plan for 2015 that included their pharmacy of choice in its network. Second, CMS had the sponsor agree to pay in-network claims at all of the pharmacies with which it had contracted during 2014,until the sponsor conducts additional beneficiary and pharmacy outreach about the network changes and contracts with additional pharmacies that will accept standard terms and conditions.

CMS will continue to monitor the sponsor's performance closely to protect beneficiaries' access to their Part D benefits. CMS is also evaluating additional steps we may be authorized to take to reduce the likelihood of future inaccuracies in plan network information provided to beneficiaries. CMS has issued multiple compliance actions to the sponsor related to the erroneous information and the overall beneficiary disruption caused by these changes. Also, we have and will continue to advise pharmacy trade associations that they should pay close attention to their process for contracting with Part D sponsors and to how their Part D plan participation information is represented by sponsors and on the MPF.

SUBMITTED FOR THE RECORD BY HON. MARIA CANTWELL

From ***Bloomberg***

U.S. to Overhaul Medicare Payments to Doctors, Hospitals

by Alexander Wayne

January 26, 2015

(Bloomberg)—The Obama administration will make historic changes to how the U.S. pays its annual $3 trillion health-care bill, aiming to curtail a costly habit of paying doctors and hospitals without regard to quality or effectiveness.

Starting next year Medicare, which covers about 50 million elderly and disabled Americans, will base 30 percent of payments on how well health providers care for patients, some of which will put them at financial risk based on the quality they deliver. By 2018, the goal is to put half of payments under the new system.

For doctors and health facilities, the system will tie tens, and then hundreds, of billions of dollars in payments to how their patients fare, rather than how much work a doctor or hospital does, lowering the curtain on Medicare's system of paying line-by-line for each scan, test and surgery.

"We believe these goals can drive transformative change," Sylvia Mathews Burwell, secretary of the Health and Human Services Department, said in the statement.

The program would be a major shift for hospitals, health facilities and physicians, eventually more than doubling the reach of programs that the U.S. said has saved $417 million and that have been a model for how the government hopes to influence, and slow down, health spending.

Medicare paid about $362 billion to care providers in 2014, the health department said in a statement, making it the biggest buyer of health care services in the U.S. Paying separately for each procedure, called "fee-for-service," has long been viewed as an inefficient driver of U.S. health spending, which at more than 17 percent of gross domestic product is the highest in the world.

Broad Reach

The Obama administration's announcement today is the first time the government has ever set specific goals to steer the nation away from fee-for-service payments.

Medicare's practices are often echoed by private insurers who cover 170 million Americans. If the U.S.'s plan is successful, non-elderly consumers could eventually

see cost savings, though they may also find that doctors and hospitals offer fewer services as they seek to cut waste and maintain profits.

Doctors and hospitals are already facing changes under the Patient Protection and Affordable Care Act, or Obamacare. About 20 percent of Medicare spending is now paid through programs in which health-care providers either take some financial risk for their performance or at least collect and report measures of their quality, the health department said. Expanding that figure was a key goal of the law.

At Risk

"The people who are delivering care are increasingly at financial risk for the services that are being rendered," Dan Mendelson, CEO of Avalere Health, a Washington consulting firm, said in a phone interview. "It's increasingly likely the physician or the hospital is going to make more money if they provide less care."

The country's main lobbying groups for doctors and hospitals said they were on board, at least with the broad idea behind the overhaul. "We support Secretary Burwell's goals and plans," said Maureen Swick, a representative of the American Hospital Association.

Robert Wah, president of the American Medical Association, said that physicians were worried about additional bureaucracy. "This idea that we're talking about delivery reform and setting up a system of delivery reform, we're very supportive of that," Wah said in an interview in Washington. "The details will be important to see."

Industry Reaction

Burwell met with about two dozen health industry officials this morning to brief them on the administration's plan. Participants included executives of Verizon Communications Inc., Boeing Co., UnitedHealth Group Inc., Anthem Inc. and representatives of large hospital chains and physician organizations.

The Affordable Care Act, often criticized by its opponents for not doing much to control health-care costs, created several programs the Obama administration now plans to rely upon to end fee-for-service payments. For example, the law penalizes hospitals with high rates of readmissions of Medicare patients within 30 days of discharging them, and encourages doctors and hospitals to band together and closely coordinate their care, with the aim of reducing redundancies and inefficiency.

Those programs have saved about 50,000 lives and reduced health-care spending by about $12 billion, based on preliminary estimates, the health department said.

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R–Utah) today delivered the following opening statement at a committee hearing on President Obama's fiscal year 2016 budget for the Department of Health and Human Services (HHS):

Good morning. It's a pleasure to welcome everyone to today's hearing on the Fiscal Year 2016 budget for the Department of Health and Human Services (HHS).

Thank you Secretary Burwell, for being here today. This is your first hearing before this committee since being confirmed, so welcome back in your official capacity.

I told you when we were talking at your confirmation hearing that the job you now have would be a thankless one and that you were undertaking an enormous responsibility. At that time, we also discussed three main areas that I encouraged you to focus on during your time at HHS: responsiveness, accountability, and independence.

I'd like to talk more about each of those areas today.

Let's start with responsiveness. During your confirmation hearing, I raised the importance of being responsive to Congress and to this committee in particular. You assured me this would be a top priority of yours as well, and that, under your watch, we would see a marked improvement.

In the past year, this committee has written at least twenty letters to HHS or CMS, asking questions about serious issues such as fraud prevention, hacking of the *HealthCare.gov* website, Medicaid expansion, and many others. I understand that

we have now received answers to nearly every one of the outstanding letters just in time for your appearance here today, with the last few responses coming just last week.

This is an improvement. And, I appreciate the efforts being made to provide these answers.

However, I hope that it will not require calling you to testify before the committee to ensure more timely responses going forward. If it does, then I suppose I will have to look forward to seeing you for a hearing every thirty to sixty days.

Thank you for continuing to make this a priority. Good communication between HHS and this committee is paramount to a good working relationship.

Now let's talk about accountability. One of the big issues we discussed at your confirmation hearing was the absolute need for fiscal accountability given the huge breadth and scope of HHS's programs and budget. Overseeing them requires constant vigilance and effective management. When looking at the size of the budget for HHS for this coming fiscal year, we see just how big a job that is.

In fact, the expression "too big to fail" does not really apply here as the HHS budget is so big one could argue that it is destined to fail.

The HHS budget for FY 2016 is just over a trillion dollars.

In real terms, if HHS were a country and its budget was its GDP, it would be the 16th largest economy in the world.

To put it in a more American context, the total budget of HHS is more than double that of Walmart and five times more than Apple.

My concern is that the savings and efficiencies in the overall HHS budget are very small when compared to the overall spending. The President's proposed budget would save just under $250 billion over the next decade, which sounds like a lot, but that is only 3.8 percent of total Medicare and Medicaid spending. More accountability is critical here to ensure these programs have sufficient resources to continue to provide benefits for years to come.

On the policy front, the administration needs to be up front to Congress about their contingency plans if the *King* v. *Burwell* case is not decided in its favor. Depending on what happens in the Supreme Court, in late June, HHS could have to figure out how to provide services for millions of Americans who are currently receiving tax subsidies that enable them to pay for health insurance. I can only assume that the agency has a plan in place for dealing with this possibility. Secretary Burwell, I hope you'll share that with us today.

That brings me to independence. For some time now, I have been concerned about the amount of influence HHS and the administration has over the operations and policies impacting the entitlement programs run by CMS. The budget released this week indicates that spending on just Medicare and Medicaid is expected to exceed $11 trillion over the next decade. In fact, CMS accounts for 85 percent of the total HHS budget.

These are astonishing numbers.

They also reinforce for me something that I have long believed: It is time to start talking about making CMS an independent agency apart from HHS.

Nearly twenty years ago, Congress passed, and the President signed into a law, the Social Security Independence and Program Improvements Act of 1994. That law separated the Social Security Administration from HHS and made it an independent agency. At that time, SSA was the largest operating division within HHS and accounted for about 51 percent of HHS's total staff and more than half of HHS's total annual budget.

I intend to introduce legislation to move CMS out of HHS.

Whether or not CMS becomes an independent agency is something to consider going forward, but the accountability and transparency problems we currently see in CMS programs cannot wait. I hope that we can work together in the coming months on both Affordable Care Act and entitlement issues to create solutions that work for all Americans.

Finally, I just want to note that while there is much in the President's budget that I disagree with, there are areas where I think we can find common ground.

For example, I appreciate the provision in the budget that addresses the issue of over-reliance on congregate care facilities or group homes for children and youth in foster care. For years, I have been working to call attention to the deplorable conditions in many of these group homes. Recent research indicates that these group homes are unsafe, expensive, and too often contribute to profoundly negative outcomes for the children and youth who are placed in them. I look forward to working with the administration to end the over-reliance on group homes.

Secretary Burwell, I look forward to your testimony today and to working with you to ensure our most vulnerable citizens get the care they deserve.

I'd now like to turn it over to Senator Wyden for his opening remarks.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

Far too many people—including millions in Oregon and across the country—feel like they're falling behind as the economy picks up steam. Congress's job is to make sure that doesn't happen. It's important for the Finance Committee to keep that challenge in focus this week as it examines the President's fiscal year 2016 budget proposals.

The budget articulates the priorities of today, and it also reflects our priorities for the future. Secretary Burwell will have the opportunity in just a moment to illustrate how the President's budget proposal aims to strengthen our health and human services programs and promote economic mobility. But I'd first like to make a few comments about where American health care has been, and where it's going.

This year marks the 50th anniversary of Medicare and Medicaid, and a lot has taken place since they were first created. Congress came together to create the Children's Health Insurance Program, or CHIP, and has reauthorized it three times. Congress has improved and expanded Medicare and Medicaid.

It passed the Affordable Care Act, making access to high-quality care wider than ever before. Thanks to five decades of progress, health care in America is no longer reserved for the healthy and the wealthy.

The job, however, is not done. Our budget must reflect a twofold commitment: first, to protect the progress that's already been made, and second, to clear the way for progress to continue in the future.

For Medicare, that means guaranteeing that the program's benefits fully meet the needs of this era's seniors. The demands on the program are different than they were 50 years ago. The big-ticket Medicare costs of 2015 are no longer things like kidney stones and broken ankles. They're chronic conditions like cancer, diabetes, and Alzheimer's that are tougher and more costly to treat. The HHS budget begins to acknowledge that reality, and bigger investments in research on chronic conditions are a positive step. But treating chronic disease is Medicare's future.

What's needed is a roadmap to efficient and effective care that moves away from fee-for-service. Patients and providers told this committee last summer about the need to address chronic care in a different way. There is bipartisan support for that in Congress, and I look forward to working with you, Secretary Burwell, and the administration to make chronic care reform a reality.

Precision medicine will need the same kind of roadmap. Medical professionals know that a treatment will often affect Susan in a different way than it affects George. And with the right research, it will be possible to learn what drives those differences and how to tailor treatments to fit an individual patient's needs. The Precision Medicine Initiative included in the President's budget proposal follows an innovative test program I fought to include in the Affordable Care Act. Looking ahead, the next step will be to design a payment system for this innovative field of medicine that will work for patients and taxpayers.

The President's budget proposal will also continue the progress made by the Affordable Care Act to reward the quality of care, rather than the quantity. Congress can do even more by passing bipartisan, bicameral legislation to improve the way Medicare pays physicians.

The President's proposal takes a vital step by including four years of funding for CHIP. There are more than 10 million kids in America who get health insurance through CHIP, including more than 75,000 in Oregon. A child who starts life with

quality health insurance has a much better shot at a successful, middle-class life than a kid who doesn't. Renewing CHIP is a no-brainer. Families and state agencies across the country are waiting for Congress to act.

These are steps Congress can take to help guarantee that our health programs remain strong for generations to come. They are lifelines for countless Americans, and as a result, millions of families will never have to choose between paying for a loved one's care and sending kids to college. And millions of kids will grow up with access to quality health care that keeps them healthy and out of the emergency rooms whenever possible.

Of course, it's important to remember that Health and Human Services does far more than oversee Medicare, Medicaid and CHIP. No department plays a bigger role preserving America's safety net than HHS. This committee has a long history of working on a bipartisan basis on policies to strengthen our federal child welfare programs for vulnerable kids.

Just five months ago, Congress enacted the Preventing Sex Trafficking and Strengthening Families Act, and HHS is helping turn this bill from a piece of paper signed by the President into new tools that help states move vulnerable kids out of harm's way and into safe and permanent homes.

The President's budget proposal shows that it's possible to build on this momentum by expanding programs that keep children and families together and healthy—particularly through early interventions like home visiting for first time parents. These multigenerational supports can help prevent the long-term costs associated with homelessness, abuse or neglect, and foster care. These investments are critical at a time when too many Americans feel like the recovery hasn't yet reached them because they're still struggling to get ahead.

Thank you, Secretary Burwell, for joining the committee today to discuss the HHS budget for the year ahead. Managing our health and human services programs is a tough job. This budget makes it clear as day that there will be many chances for the Finance Committee and the administration to work together to protect those programs today and in the future.

COMMUNICATION

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February 10, 2015

The Honorable Orrin Hatch, Chairman
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden, Ranking Member
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

Dear Senator Hatch and Senator Wyden,

We write to express our support to members of the Senate and to members of the Senate Finance Committee for encouraging the Centers for Medicare & Medicaid Services (CMS) to take steps to alter the Star ratings program to account for underlying differences in Medicare Advantage (MA) plans' enrolled populations. Forty Senators submitted a letter to Administrator Tavenner on February 3, 2015, and this issue was also raised during the Senate Finance Committee's February 4 hearing. We believe that the Star ratings program, in its current form, disadvantages health plans that enroll dual eligible beneficiaries. We applaud the Senators for urging CMS to use its existing regulatory and administrative authority to improve the Star ratings program so that the quality of care MA plans provide to dual-eligible beneficiaries can be accurately measured and compared across plans.

Dual-eligible beneficiaries are among the poorest, sickest, and most costly individuals to both the Medicare and Medicaid programs. They often fall through the cracks between the two programs, and many of these beneficiaries experience uncoordinated care in Medicare and Medicaid fee-for-service (FFS). D–SNPs are an opportunity for these beneficiaries to receive better coordinated care and higher quality of care than they would otherwise receive through FFS. Unlike other types of MA plans, D–SNPs exclusively enroll and focus their provider networks, benefit packages, and care management resources specifically on dual-eligible beneficiaries.

The inability of the Star ratings program to accurately assess and compare quality measures for dual-eligible beneficiaries is a consumer issue as well as a plan issue. Dual-eligible beneficiaries will lose if their health plans—particularly those that integrate all of their Medicare and most of their Medicaid benefits—are no longer financially able to continue serving them due to low reimbursement on account on inaccurate Star ratings.

We support a Star ratings program that evaluates and compares all MA plans based on the quality of care they furnish, rather than on the underlying characteristics and needs of their enrollee population.

We have asked CMS to improve the program by:

1. Using quality measures that are appropriate for dual-eligible beneficiaries with complex health, behavioral, and cognitive needs;

2. Reporting and applying quality ratings of D–SNPs at the plan level instead of the contract level; and

3. Comparing D–SNPs to other D–SNPs that enroll similar populations.

We have also asked Congress to require the Government Accountability Office (GAO) to conduct a study to determine how the Secretary could change the Star ratings program to accurately compare the quality of care provided by individual D–SNPs (and D–SNPs as a whole) to the quality of care dual-eligible beneficiaries receive under Medicare FFS and other MA plans with similar populations.

It is a high priority for our D–SNP member plans that the quality of care they provide to their dual-eligible enrollees is accurately measured and reported to consumers. We will continue to work with our member plans to identify ways to improve the accuracy of the Star ratings program. We hope that the experience of our member plans in serving some of the most complex, challenging, and costly Medicare and Medicaid beneficiaries is a resource to the Congress and to CMS as the MA program is improved, so that all Medicare beneficiaries have the opportunity to receive better quality of care through this program.

ACAP is prepared to assist with additional information, if needed. If you have any additional questions please do not hesitate to contact Christine Aguiar at (202) 204–7519 or *caguiar@communityplans.net.*

Sincerely,

Margaret A. Murray
Chief Executive Officer